(15)

No. 99-830-CFX Title: Don Stenberg, Attorney General of Nebraska, et al., Petitioners
v.
Leroy Carhart

Docketed:
November 15, 1999 Court: United States Court of Appeals for the Eighth Circuit

Entry	Date	Proceedings and Orders
	Nov 15 1999	Petition for writ of certiorari filed. (Response due December 15, 1999)
	Nov 15 1999	40 copies supplemental appendix to the petition for a writ of certiorari filed.
	Dec 13 1999	Waiver of right of respondent Mike Munch to respond filed.
	Dec 14 1999	Brief of respondent Leroy Carhart in opposition filed.
	Dec 17 1999	LODGING consisting of an audio tape of oral argument before the 8th Circuit Court of Appeals submitted by counsel for the respondent
	Dec 22 1999	Reply brief of petitioners Don Stenberg, NE, Attorney General, et al. filed.
	Dec 29 1999	DISTRIBUTED. January 14, 2000
	Jan 4 2000	Motion of Alabama, et al. for leave to file a brief as amici curiae filed.
	Jan 14 2000	Motion of Alabama, et al. for leave to file a brief as amici curiae GRANTED.
	Jan 14 2000	Petition GRANTED. limited to Questions 1 and 2 presented by the petition. Brief of petitioners is to be filed with the Clerk andserved upon opposing counsel on or before 3 p.m., Monday, February 28, 2000. Brief of respondent is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Wednesday, March 29, 2000. A reply brief, if any, is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Monday, April 17, 2000. Rule 29.2 does not apply. SET FOR ARGUMENT April 25, 2000. **********
	Jan 14 2000	Motions to file briefs as amicus curiae and any motions relating to oral argument must be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Monday, March 27, 2000. Rule 29.2 does not apply.
	Feb 14 2000	Motion of Alan Ernest for leave to represent children unborn and born alive filed.
	Feb 14 2000	Motion of Alan Ernest for leave to file a brief as amicus curiae filed.
	Feb 17 2000	Brief amici curiae of Feminists for Life of America, et al. filed.
	Feb 23 2000	Brief amici curiae of United States Catholic Conference, et al. filed.
	Feb 23 2000	Motion of Rutherford Institute for leave to file a brief as amicus curiae filed.
	Feb 25 2000	Brief amicus curiae of Wisconsin filed.
	Feb 25 2000	Brief amici curiae of Louisiana and Mississippi filed.
	Feb 25 2000	Motion of National Association of Prolife Nurses, Inc. for leave to file a brief as amicus curiae filed.

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Entry	Date	Proceedings and Orders
	Feb 28 2000	Joint appendix filed.
	Feb 28 2000	Joint appendix in three volumes.
	Feb 28 2000	Brief of petitioners Don Stenberg, Attorney General of Nebraska, et al. filed.
	Feb 28 2000	Brief amicus curiae of Agudath Israel of America (TO BE REPRINTED) filed.
	Feb 28 2000	Brief amici curiae of Charles Canady, et al. filed.
	Feb 28 2000	Brief amicus curiae of Family Research Council filed.
	Feb 28 2000	Brief amici curiae of National Right to Life Committee, et al. filed.
	Feb 28 2000	Brief amicus curiae of Knights of Columbus filed.
	Feb 28 2000	Brief amicus curiae of Texas filed.
	Feb 28 2000	Brief amicus curiae of American Center for Law and Justice filed.
	Feb 28 2000	Brief amici curiae of Virginia, et al. filed.
	Feb 28 2000	Brief amici curiae of Association of American Physicians and Surgeons, et al. filed.
	Feb 28 2000	Brief amicus curiae of Family First filed.
	Feb 28 2000	LODGING consisting of one bound copy of original documents that appear in appendix of amicus brief of Family First.
	Feb 28 2000	Motion of Right to Life Advocates, Inc. for leave to file a brief as amicus curiae filed.
	Feb 28 2000	Motion of National Association for the Protection of Unborn Children for leave to file a brief as amicus curiae filed.
	Feb 29 2000	Motion of James J. Clancy for leave to file a brief as amicus curiae filed.
	Feb 29 2000	LODGING consisting of one copy of City of Santa Ana amicus brief filed in 80-1604 submitted by counsel James Clancy
	Feb 29 2000	Motion of Texas Black Americans for Life, et al. for leave to file a brief as amicus curiae filed.
	Mar 1 2000	Record filed.
	Mar 3 2000	Motion of Alan Ernest for leave to represent children unborn and born alive DISTRIBUTED.
	Mar 3 2000	Motion of Alan Ernest for leave to file a brief as amicus curiae DISTRIBUTED.
	Mar 6 2000	Motion of Alan Ernest for leave to represent children unborn and born alive DENIED.
	Mar 6 2000	Motion of Alan Ernest for leave to file a brief as amicus curiae DENIED.
	Mar 6 2000	Record filed.
	Mar 10 2000	CIRCULATED.
	Mar 17 2000	Motion of National Association for the Protection of Unborn Children for leave to file a brief as amicus curiae DISTRIBUTED.
	Mar 17 2000	Motion of National Association of Prolife Nurses, Inc. for leave to file a brief as amicus curiae DISTRIBUTED.
	Mar 17 2000	Motion of Right to Life Advocates, Inc. for leave to file a brief as amicus curiae DISTRIBUTED.

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Entry	Date	Proceedings and Orders
	Mar 17 2000	Motion of James J. Clancy for leave to file a brief as amicus curiae DISTRIBUTED.
	Mar 17 2000	Motion of Texas Black Americans for Life, et al. for leave to file a brief as amici curiae DISTRIBUTED.
	Mar 20 2000	Motion of National Association of Prolife Nurses, Inc. for leave to file a brief as amicus curiae GRANTED.
	Mar 20 2000	Motion of Right to Life Advocates, Inc. for leave to file a brief as amicus curiae DENIED.
	Mar 20 2000	Motion of National Association for the Protection of Unborn Children for leave to file a brief as amicus curiae DENIED.
	Mar 20 2000	Motion of James J. Clancy for leave to file a brief as amicus curiae DENIED.
	Mar 20 2000	Motion of Texas Black Americans for Life, et al. for leave to file a brief as amici curiae DENIED.
	Mar 28 2000	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Mar 29 2000	Brief of respondent Leroy Carhart filed.
	Mar 29 2000	Brief amici curiae of Barbara Boxer, Nita Lowey, et al. filed.
	Mar 29 2000	Brief amici curiae of Planned Parenthood of Wisconsin, et al. filed.
	Mar 29 2000	Brief amici curiae of American College of Obstetricians and Gynecologists, et al. filed.
	Mar 29 2000	Brief amici curiae of American Civil Liberties Union, et al. filed.
	Mar 29 2000	Brief amici curiae of Religious Coalition for Reproductive Choice, et al. filed.
	Mar 29 2000	Brief amicus curiae of California Attorney General Bill Lockyer filed.
	Mar 29 2000	Brief amicus curiae of Seventy-Five Organizations Committed to Women's Equality filed.
	Mar 29 2000	Brief amici curiae of NARAL Foundation, et al. filed.
	Mar 29 2000	Brief amici curiae of New York, et al. filed.
	Mar 29 2000	LODGING consisting of twenty bound copies of appendix material submitted by counsel for amicus Planned Parenthood and distributed.
	Mar 29 2000	Brief amicus curiae of United States filed.
	Mar 30 2000	Motion of the Solicitor General for leave to participate in oral argument as amicus curaie and for divided argument DISTRIBUTED.
	Apr 3 2000	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument DENIED.
	Apr 17 2000	Reply brief of petitioners Don Stenberg, Attorney Gereral, et al. filed.
	Apr 19 2000	Letter from amici counsel Robert Lewin received and distributed.
	Apr 20 2000	Motion of Rutherford Institute for leave to file a brief as amicus curiae DISTRIBUTED.

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Entry	Date	Proceedings and Orders
	Apr 24 2000	Motion of Rutherford Institute for leave to file a brief as amicus curiae GRANTED.
	Apr 25 2000	ARGUED.

(1)

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OFFICE OF THE CLERK

In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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116pp

QUESTIONS PRESENTED

I. Whether the Eighth Circuit's adoption of a broad unconstitutional reading of Nebraska's ban on partial-birth abortion, which directly conflicts with the narrower constitutional construction of similar statutes by the Seventh Circuit Court of Appeals and that of the State officials charged with enforcement of the statute, violates fundamental rules of statutory construction and basic principles of federalism in contradiction of the clear direction of this Court in ***Webster v. Reproductive Health Services***?

II. Whether the Eighth Circuit misapplied this Court's instructions in ***Planned Parenthood v. Casey*** by finding that a law banning cruel and unusual methods of killing a partially-born child, is an "undue burden" on the right to abortion?

III. Whether a living human being delivered from its mother's body up to its head is a person for purposes of the Fourteenth Amendment?

IV. Whether, in light of the physical cruelty of abortion; the termination of over 38 million unborn and partially born children since 1973; the extensive litigation that continues unabated on this divisive issue; the polarization of the body politic; the ability of elected lawmakers to balance competing interests; and the lack of any constitutional textual basis, the Court should now recognize that abortion is more properly a public policy legislative matter than a constitutional issue for judicial decision?

LIST OF PARTIES

The Petitioners are Don Stenberg, Attorney General of the State of Nebraska; Gina Dunning, Director of Regulation and Licensure of the Nebraska Department of Health and Human Services; and Charles Andrews, M.D., Chief Medical Officer of the State of Nebraska. An additional Appellant/Defendant below was Mike Munch, Sarpy County Attorney.

The Respondent is LeRoy H. Carhart, M.D.

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PETITION FOR A WRIT OF CERTIORARI

Nebraska Attorney General Don Stenberg respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit has not yet been officially reported. It can be found at 1999 WL 753919 and 1999 U.S. App. Lexis 23162. The opinion is set forth in the Appendix (App.1). The opinions of the United States District Court for the District of Nebraska in this case are reported at 972 F. Supp. 507 and 11 F. Supp.2d 1099.

The conflicting opinion of the United States Court of Appeals for the Seventh Circuit, ***The Hope Clinic v. Ryan,*** has not been officially reported. It can be found at 1999 WL 974098. This opinion is also set forth in the Appendix (App.23).

JURISDICTION

The opinion and the judgment of the United States Court of Appeals for the Eighth Circuit were entered on September 24, 1999. Jurisdiction in this Court exists under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

I. Neb. Rev. Stat. § 28-326(9) (Supp.1998):

> Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. For purposes of this subdivision, the term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.

II. Neb. Rev. Stat. § 28-328(1) – (4) (Supp.1998):

> (1) No partial-birth abortion shall be performed in this state, unless such procedure is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.
>
> (2) The intentional and knowing performance of an unlawful partial-birth abortion in violation of subsection (1) of this section is a Class III felony.
>
> (3) No woman upon whom an unlawful partial-birth abortion is performed shall be prosecuted under this section or for conspiracy to violate this section.

> (4) The intentional and knowing performance of an unlawful partial-birth abortion shall result in the automatic suspension and revocation of an attending physician's license to practice medicine in Nebraska by the Director of Regulation and Licensure. . . .

III. U.S. Const. amendment XIV:

The Fourteenth Amendment provides in pertinent part: "Nor shall any State Deprive any person of life, liberty, or property without due process of law."

STATEMENT OF THE CASE

In the past four years, nearly two-thirds of the State legislatures, as well as the United States Senate and House of Representatives, have each addressed growing public concern over a controversial medical procedure legally denominated as "partial-birth abortion" and now referred to medically as "D&X" abortion. So repulsed by the procedure were legislators across the country that statutory bans on partial-birth abortion were passed by thirty States and both houses of Congress. As one federal court described it, partial-birth abortion "is gruesome and inhumane." ***Evans v. Kelley,*** 977 F. Supp. 1283, 1319 n.38 (E.D. Mich. 1997). Even some abortion practitioners believe it "is a particularly hideous procedure." ***Id.***

The United States District Court for the District of Nebraska described the partial-birth abortion/D&X procedure as follows, based on testimony in the present case:

> When the fetus is presented feet first, Carhart, using forceps, pulls the feet of the living

fetus from the uterus into the vaginal cavity and then pulls the remainder of the fetus, except the head, into the vaginal cavity to a point where the base of the fetal skull is lodged in the uterine side of the cervical canal. At that point, the size of the head will not permit him to pull it through the cervical canal into the vaginal cavity. To decompress the fetal skull and evacuate the contents in order to pull it through the cervical canal, Carhart uses an instrument to either tear or perforate the skull to allow insertion of a cannula and removal of the cranial contents. Sometimes he will crush the skull rather than pierce it in order to reduce the size of the skull. Brain death occurs sometime during this two-to-three-second reduction procedure, but fetal heart function may continue for several seconds or minutes after the fetus's skull is decompressed.

Carhart v. Stenberg, 11 F. Supp.2d 1099, 1106 (D.Neb. 1998).

One nurse who personally observed the partial-birth abortion/ D&X procedure stated, "I have been a nurse for a long time, and I have seen a lot of death – people maimed in auto accidents, gunshot wounds, you name it. I have seen surgical procedures of every sort. But in all my professional years, I had never witnessed anything like this." Hearing Before the Senate Judiciary Committee on H.R. 1833, Nov. 17, 1995, Hearing Transcript at pp. 17-18 (Statement of Brenda Pratt Shafer, R.N.).

Nurse Shafer described the procedure's effect on a partially-born child as follows:

> [The physician] brought the ultrasound in and hooked it up so that he could see the baby.

> On the ultrasound screen, I could see the heart beat. As [the doctor] watched the baby on the ultrasound screen, *the baby's heartbeat was clearly visible on the ultrasound screen.*
>
> [The doctor] went in with the forceps and *grabbed the baby's legs and pulled them down into the birth canal.* Then he delivered the baby's body and the arms – everything but the head. *The doctor kept the head right inside the uterus.*
>
> . . .
>
> *The baby's little fingers were clasping and unclasping, and his little feet were kicking. Then the doctor stuck the scissors in the back of his head, and the baby's arms jerked out, like a startle reaction, like a flinch, like a baby does when he thinks he is going to fall.*
>
> *The doctor opened up the scissors, stuck a high-powered suction tube into the opening, and sucked the baby's brains out. Now the baby went completely limp.*
>
> I was really completely unprepared for what I was seeing. I almost threw up as I watched [the doctor] doing these things. Next, [the doctor] delivered the baby's head. He cut the umbilical cord and delivered the placenta. He threw the baby in a pan, along with the placenta and the instruments he had just used. I saw the baby move in the pan. I asked another nurse, and she said it was just reflexes.

Id.

The Nebraska Legislature, with only one dissenting vote, passed a statutory ban on partial-birth abortion which was signed into law on June 9, 1997. Nebraska's statute was patterned closely after language passed by

both houses of Congress. On June 12, 1997, LeRoy Carhart, M.D., a Bellevue, Nebraska physician who performs late-term abortions, filed a Complaint challenging the constitutionality of Nebraska's statute. On June 17, 1997, the United States District Court for the District of Nebraska entered a Temporary Restraining Order suspending enforcement of LB 23, which remained in effect pending disposition of the Plaintiff's Motion For Preliminary Injunction. A preliminary injunction hearing was held on July 17 and 18, 1997. On August 14, 1997, the court granted a preliminary injunction.

Following additional discovery, a trial on the merits was held on March 24, 1998, at which time additional testimony and evidence was received. On July 2, 1998, the district court permanently enjoined enforcement of the statute. Final Judgment was entered on August 10, 1998. An appeal was taken to the Eighth Circuit Court of Appeals pursuant to 28 U.S.C. § 1291, and on September 24, 1999, that court affirmed the judgment of the district court.

Notwithstanding the position of the Nebraska Attorney General that the D&E abortion procedure was not encompassed by the statute, the Eighth Circuit panel construed Nebraska's statute as banning not only the partial-birth abortion/D&X procedure, but also the more common D&E procedure. The panel concluded that such a prohibition "imposes an undue burden on a woman's right to choose to have an abortion." ***Carhart v. Stenberg,*** ___ F.3d ___, 1999 WL 753919 (8th Cir. 1999) (App.19).

REASONS FOR GRANTING THE WRIT

I. The Eighth Circuit's Reading of Nebraska's Partial-Birth Abortion Statute Directly Conflicts With the Seventh Circuit's Reading of Partial-Birth Abortion Statutes Enacted By the States of Wisconsin and Illinois.

The Court should grant certiorari in this case to resolve a conflict between two United States courts of appeals on the same important matter.

On September 24, 1999, the United States Court of Appeals for the Eighth Circuit declared Nebraska's partial-birth abortion statute to be unconstitutional. ***Carhart v. Stenberg,*** ___ F.3d ___, 1999 WL 753919 (8th Cir. 1999) (App.1). On October 26, 1999, the United States Court of Appeals for the Seventh Circuit, sitting en banc, upheld partial-birth abortion statutes enacted by the States of Wisconsin and Illinois. ***The Hope Clinic v. Ryan*** and ***Christensen v. Doyle,*** ___ F.3d ___, 1999 WL 974098 (7th Cir. 1999) (en banc) (App.23). The Eighth Circuit's broad unconstitutional reading of Nebraska's partial-birth abortion statute directly conflicts with the Seventh Circuit's decision in ***Hope Clinic***. Thus, "a United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter." Supreme Court Rule 10(a).

All three statutes reviewed by the Seventh and Eighth Circuits in ***Hope Clinic*** and ***Carhart*** define partial-birth abortion in substantially the same terms. The Illinois legislature defined partial-birth abortion as "an abortion in which the person performing the abortion partially vaginally delivers a living human fetus or infant

before killing the fetus or infant and completing the delivery." 720 Ill. Comp. Stat. § 513/5 (App.27). The Wisconsin legislature defined partial-birth abortion as "an abortion in which a person partially vaginally delivers a living child, causes the death of the partially delivered child with the intent to kill the child, and then completes the delivery of the child." Wis. Stat. § 940.16(b) (App.29). Similarly, the Nebraska legislature defined partial-birth abortion as "an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery." Neb. Rev. Stat. § 28-326(9).

In discussing the Illinois and Wisconsin statutes in light of the Eighth Circuit's decision, the Seventh Circuit stated:

> Plaintiffs in both [the Illinois and Wisconsin] cases contend that, even if the statutes are precise enough to be enforced, they create an undue (and therefore unconstitutional) burden on abortion. The eighth circuit reached this conclusion in ***Carhart*** and its two companion cases, but only after first holding that the state laws effectively prohibit the D&E procedure. If we thought that the Illinois or Wisconsin laws forbade D&E, then ***Planned Parenthood of Central Missouri v. Danforth*** would require us to agree with the eighth circuit. For reasons we have already given, however, we believe that state courts are entitled to accept the view of both states' Attorneys General that their laws do not forbid, or even affect, the D&E procedure. The question we must address, then, is whether a statue limited to D&X unduly burdens abortion.

Hope Clinic, ___ F.3d ___ (App.48).

Thus, the Seventh Circuit appropriately adopted a saving construction of the Illinois and Wisconsin statutes, while the Eighth Circuit chose a broad unconstitutional reading of Nebraska's statute. This was despite the fact that the Nebraska Attorney General, like those of Illinois and Wisconsin, took the position that the D&E procedure was not prohibited by the statute. These two decisions create a clear conflict pursuant to Supreme Court Rule 10(a) which should be resolved by this Court.

II. The Eighth Circuit's Broad Reading of Nebraska's Partial-Birth Abortion Statute Violates Fundamental Rules of Statutory Construction and Basic Principles of Federalism in Contradiction of the Clear Direction of this Court and in Conflict with the Reading of Such Statutes by the Seventh Circuit Court of Appeals.

The Court should grant certiorari in this case to address the failure of the Eighth Circuit panel to follow the Court's previous decisions upholding important principles of federalism as reflected in fundamental rules of statutory construction which favor constitutional interpretations of State statutes.

In ***Webster v. Reproductive Health Services***, 492 U.S. 490, 109 S.Ct. 3040 (1989), the Court considered the constitutionality of a Missouri statute that required viability testing "[b]efore a physician performs an abortion on a woman he has reason to believe is carrying an unborn child of twenty or more weeks gestational age. . . . " ***Id.*** at 3054. In its opinion the Court chastised the Eighth Circuit panel (which had declared the statute unconstitutional)

for its interpretation of the statute which "runs 'afoul of the well-established principle that statutes will be interpreted to avoid constitutional difficulties.' " *Id.* at 3054 (quoting *Frisby v. Schultz*, 487 U.S. 474, 483 (1988)). As in *Webster*, the Eighth Circuit panel in the present case failed to follow this basic rule of statutory construction.

This rule of construction favoring constitutionality of State statutes is rooted in important concepts of federalism, and is particularly important when considering State partial-birth abortion statutes. *See* Note, 112 Harv.L.Rev. 731 (1999). As noted by Sixth Circuit Judge Boggs, "The Supreme Court has reminded us time and again that, rather than reaching out to strike down statutes that are arguably unconstitutional, the federal courts are to interpret statutes so as to avoid difficult constitutional questions where possible." *Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187, 212 (6th Cir. 1997) (Boggs, dissenting). *See also id.* ("the majority's opinion strains to interpret Ohio's partial-birth abortion statute so as to make the burden . . . undue in violation of *Casey*."); *Richmond Medical Center For Women v. Gilmore*, 144 F.3d 326, 332 (4th Cir. 1998) (Circuit Judge Luttig discussing the district court's failure to construe Virginia's partial-birth abortion statute according to rules of construction and federalism). *Compare The Hope Clinic v. Ryan*, ___ F.3d ___ (7th Cir. 1999) (App.48) (employing a saving construction of Illinois' and Wisconsin's partial-birth abortion statutes); *Planned Parenthood of Wisconsin v. Doyle*, 162 F.3d 463, 474 (7th Cir. 1998) (Manion, dissenting) ("The district court has given the statute its proper (and logical) narrow construction, thus confining the ban to the D & X abortion procedure."); *Planned*

Parenthood of Wisconsin v. Doyle, 9 F. Supp.2d 1033, 1041, 1042 (W.D. Wis. 1998) (employing a narrow construction of Wisconsin's partial-birth abortion ban).

In construing Nebraska's statute, the Eighth Circuit acknowledged "The State argues that LB 23's ban on partial-birth abortion prohibits only the D&X procedure, and not the D&E." *Carhart*, ___ F.3d ___ (App.16). However, unlike the Seventh Circuit, the court refused to give the statute that construction. This Court should grant a writ of certiorari in this case to uphold its prior admonitions to federal courts concerning rules of construction and principles of federalism in the context of reviewing State legislative enactments.

III. The Eighth Circuit has Misapplied the Court's Instructions in *Planned Parenthood v. Casey* by Finding a Ban on a Cruel and Unusual Method of Killing a Partially-Born Child to be an "Undue Burden" on the Right to Abortion.

The Court should grant certiorari in this case to enforce and further clarify its undue burden test as set forth in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 112 S.Ct. 2791 (1992), as the Court's important holdings in *Casey* concerning the legitimate interests of the States are not being implemented by the lower federal courts.

The American College of Obstetricians and Gynecologists, a staunch defender of abortion rights and an opponent of bans on partial-birth abortion, has reported that "A select panel convened by ACOG could identify no circumstances under which this [D&X] procedure . . .

would be the only option to save the life or preserve the health of the woman." In other words, safe alternatives are available.

If a State cannot ban the partial-birth abortion/D&X procedure, there is effectively no limit on abortion at all. Such a result conflicts with the Court's decisions in both ***Casey*** and ***Roe v. Wade***. In ***Roe v. Wade,*** the Court emphatically noted that "appellant and some amici argue that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, *in whatever way*, and for whatever reason she alone chooses. *With this we do not agree.*" ***Roe v. Wade,*** 410 U.S. 113, 99 S.Ct. 705, 727 (1973) (emphasis added). Likewise, in ***Casey,*** the Court stated, "The very notion that the State has a substantial interest in potential life leads to the conclusion that not all regulations must be deemed unwarranted. Not all burdens on the right to decide whether to terminate a pregnancy will be undue." ***Casey,*** 505 U.S. at 876, 112 S.Ct. at 2820.

The Court has never elaborated on the application of the undue burden test since ***Casey***, and should grant certiorari in this case to enforce and clarify the applicable standard, as well as reinforce the Court's holdings concerning the legitimate interests of the States.

IV. This Case Squarely Presents the Important Issue of Whether Partially-Born Human Beings, Like African Americans and Native Americans, are Persons for Purposes of the Fourteenth Amendment.

The Court should grant certiorari in this case to address the important question of whether a human

being delivered all but a few inches from the womb is a person for purposes of the Fourteenth Amendment.

As the federal district court below noted, "there is no precedent" regarding the treatment of partially-born children as persons. ***Carhart,*** 972 F. Supp. 507, 529 (D.Neb. 1997). Therefore, this question is a matter of first impression. In such cases, basic principles of federalism as well as this Court's admonitions in ***Casey,*** favor deference towards a State's legislative judgment. As the Court emphasized in ***Casey,*** the States' interests in preserving human life have not, heretofore, been given due regard by the lower courts. ***Casey,*** 112 S.Ct. at 2817. Since there is no precedent from this Court prohibiting States from protecting partially-born human beings, it is appropriate to defer to a State's legislative determination.

Federal courts have faced similar questions throughout the history of the development of civil rights in the United States. In 1856, the Court held that a "free negro of the African race, whose ancestors were brought to this country and sold as slaves, is not a 'citizen' within the meaning of the Constitution of the United States" and "the special rights and immunities guaranteed to citizens do not apply to them." ***Dred Scott v. Sandford,*** 19 How. 393, 15 L.Ed. 691 (1856) (from syllabus I 4, 5, 6). This infamous decision was eventually overturned on the battlefields of the Civil War. Despite the ratification of the Fourteenth Amendment in 1868, however, the treatment of some individuals as "nonpersons" persisted in the courts. In fact, Native Americans were not recognized as "persons" under the laws of the United States until 1879. ***Standing Bear v. Crook,*** 25 Fed. Cas. 695, 697 (D.Neb. 1879).

In 1973, the Court held that notwithstanding "the well-known facts of fetal development," the "unborn" are not "persons" under the Fourteenth Amendment. ***Roe v. Wade,*** 410, U.S. 113, 155, 162, 93 S.Ct. 705, 728, 731 (1973). The result has been that more than one of every four American children conceived since 1973 has been aborted, the vast majority for purely elective reasons. Statistical Abstract of the United States, U.S. Bureau of the Census 117th ed. (1997).

Now numerous courts nationwide are faced with the question of whether partially-born human beings, delivered all but inches outside of the womb, are "persons" under the Fourteenth Amendment. In its preliminary injunction memorandum, the federal district court below brushed this issue aside by noting that "there is no precedent" for treating partially-born human beings as persons. Amazingly, this is, in essence, the same argument made by the federal authorities in support of denying civil rights protection to Standing Bear and thirty-five other Native Americans in April of 1879 – in the same court. In ***Standing Bear v. Crook***, Federal District Judge Dundy expressly addressed and rejected this argument:

> I must hold, then, that Indians, and consequently the realtors, are "persons," such as are described by and included within the laws before quoted. *It is said, however, that this is the first instance on record in which an Indian has been permitted to sue out and maintain a writ of habeas corpus in a federal court . . . and therefore the court must be without jurisdiction in the premises. This is a non sequitur. I confess I do not know of another instance where this has been done, but I can also say*

> *that the occasion for it perhaps has never before been so great.*

Standing Bear v. Crook, 25 Fed. Cas. at 697 (emphasis added).

The Eighth Circuit, when presented with this issue, stated that "The phrase 'partially born' is new to us. Apparently the State uses it to describe a process in which the fetus is killed when it is more outside the womb than inside." ***Carhart v. Stenberg,*** ___ F.3d ___ (App.19). However, since the court read the Nebraska statute as encompassing the D&E abortion procedure as well as the D&X, the court concluded the State's "argument is still unavailing. . . . ". ***Id.*** Incredibly, and in contradiction of long established precedent, the Eighth Circuit panel went on to declare "[W]e think that the word 'born' refers most naturally to a *viable* fetus, one that is capable of surviving outside the mother." ***Id.*** (emphasis added). This statement cries out for correction by this Court. Centuries before current ultrasound technology and modern fetal medicine, it was recognized that a child born alive was a person regardless of "viability." The Eighth Circuit's imposition of a new viability requirement on personhood is unprecedented and clearly wrong. ***See Showry v. Texas,*** 690 S.W.2d 689, 692 (Tex. App. 1985) (detailed discussion of the irrelevance of viability once delivery of a living child has occurred).

The fact that there is no clear precedent regarding the status of partially-born children does not mean the Court must conclude that they are without constitutional protection. The Court should refuse to add partially-born human beings to the infamous list of those considered

"nonpersons." If a corporation may be a "person," ***Met. Life Ins. Co. v. Ward,*** 470 U.S. 869, 105 S.Ct. 1676 n.9 (1985) (noting that "a corporation is a 'person' within the meaning of the Fourteenth Amendment"), surely a partially-born human being, just inches from complete independence, is a person as well. While "the unborn" have been denied status as persons under the Fourteenth Amendment, the partially-born have never been relegated to this sub-person status. ***See Roe v. Wade,*** 410 U.S. 113, 118 n.1, 93 S.Ct. 705 (1973); ***Showry v. Texas,*** 690 S.W.2d 689, 692 (Tex. App. 1985).

In sum, there is no logical basis to conclude that a child that is delivered all except its head is a "nonperson", but the same child delivered an additional few inches is a "person". Such a distinction is irrational and arbitrary. Irrational and arbitrary distinctions, especially in the context of life and death, are a cancer on the rule of law and breed disrespect and mistrust of the judicial system. Such a reading of the Fourteenth Amendment is contrary to sound logic and law, and is not dictated by any decision of this Court. The Fourteenth Amendment should not be read as excluding partially-born children from legal protection, and the Court should grant certiorari on this question to establish this important constitutional principle.

V. This Case Presents the Court with an Opportunity to Revisit the Underpinnings of Abortion Jurisprudence in Light of Nearly Eight Years of Additional Litigation Experience in the Federal Courts Since the *Casey* Decision.

The unprecedented legislative action by thirty States to ban an abortion procedure, and the conflict which has

developed between the circuits on this issue, now presents the Court an opportunity to revisit the foundational underpinnings of abortion jurisprudence in light of nearly eight additional years of litigation experience in the federal courts since the *Casey* decision.

The fundamental public policy issue involved in abortion is one that defies judicial determination. That issue is when should an unborn human being's life be protected by law? When she has fingers and toes? When her heart begins to beat? When she has brain waves? When she can move her legs and press against her mother's stomach?

The fact is, the Constitution of the United States makes no attempt to comment upon, let alone decide, this issue. It is necessarily a value judgment and a moral judgment, not a Constitutional question. As such, it is a judgment to be made by elected lawmakers and not by the judiciary.

Does the mother have an interest in this question? Certainly. And the mothers, the fathers, and their representatives are fully capable of lobbying legislators, testifying at hearings and voting in elections to affect the legislative balance.

Chopping unborn children into pieces, or pulling first one arm off and then the other, as described by Dr. Carhart in his testimony about D&X and D&E abortions, is a ghastly, cruel and painful practice. It would be cruel and unusual punishment if inflicted on a convicted murderer. The proper place to balance the grotesque death of an unborn girl or boy against the inconvenience and pain of childbirth is in the state legislature.

In light of the physical cruelty of abortion; the termination of over 38 million unborn and partially-born children since 1973; the extensive litigation that continues unabated nationwide on this divisive issue; the polarization of the body politic; the ability of elected lawmakers to balance competing interests; and the lack of any constitutional textual basis for the right to abortion, the Court should now recognize that abortion is more properly a public policy legislative matter than a constitutional issue for judicial decision.

CONCLUSION

It shocks the conscience that in the United States of America a human child can be literally pulled from the womb and then cruelly killed by having his or her skull punctured and brains suctioned out. The State of Nebraska has a legitimate interest in banning this barbarous procedure, and the Petitioners respectfully request the Court to grant a writ of certiorari on each of the questions presented herein.

Respectfully submitted,

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APPENDIX

United States Court of Appeals
FOR THE EIGHTH CIRCUIT

Nos. 98-3245NE, 98-3300NE

No. 98-3245NE

Leroy H. Carhart, on behalf of himself and his patients obtaining abortions,

Appellee,

v.

Donald Stenberg, in his official capacity as Attorney General for the State of Nebraska,

Appellants,

Mike Munch, in his official capacity as County Attorney for Sarpy County, and as a representative of all County Attorneys in Nebraska,

Defendant,

Gina Dunning, in her official capacity as Director of Regulation and Licensure of the Nebraska Department of Health and Human Services, and Charles Andrews, M.D., in his official capacity as Chief Medical Officer of Nebraska,

Appellants,

On Appeal from the United States District Court for the District of Nebraska.

(Filed Sep. 24, 1999)

State of South Carolina; State of Idaho; State of Louisiana; State of Ohio; State of Pennsylvania; State of Rhode Island; State of South Dakota; and State of Utah,

Amici Curiae,

Family Research Council,

Amicus Curiae.

No. 98-3300NE

Leroy H. Carhart, on behalf of himself and his patients obtaining abortions,

Appellee,

v.

Donald Stenberg, in his official capacity as Attorney General for the State of Nebraska,

Appellee,

Mike Munch, in his official capacity as County Attorney for Sarpy County, and as a representative of all County Attorneys in Nebraska,

Appellant,

Gina Dunning, in her official capacity as Director of Regulation and Licensure of the Nebraska Department of Health and Human Services, and

Charles Andrews, M.D., in his official capacity as Chief Medical Officer of Nebraska,

Appellees,

State of South Carolina; State of Idaho; State of Louisiana; State of Ohio; State of Pennsylvania; State of Rhode Island; State of South Dakota; and State of Utah,

Amici Curiae,

Family Research Council,

Amicus Curiae.

Submitted: April 19, 1999
Filed: September 24, 1999

Before RICHARD S. ARNOLD and WOLLMAN,[1] Circuit Judges, and MAGNUSON,[2] District Judge.

RICHARD S. ARNOLD, Circuit Judge.

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[1] The Hon. Roger L. Wollman became Chief Judge of this Court on April 24, 1999.

[2] The Hon. Paul A. Magnuson, Chief Judge, United States District Court for the District of Minnesota, sitting by designation.

The State of Nebraska appeals a District Court[3] decision holding a Nebraska statute banning "partial-birth abortion" unconstitutional. The District Court permanently enjoined enforcement of the statute and awarded attorney's fees and costs to the plaintiff. The County Attorney, named in the lawsuit in his official capacity and as a representative of all county attorneys, appeals the portion of the judgment awarding attorney's fees against him. For the following reasons, we affirm the judgment of the District Court.

It is important to have in mind that we deal here with a particular legal question: the validity, under the Constitution of the United States, of a certain Nebraska law. The law refers to "partial-birth abortion," but this term, though widely used by lawmakers and in the popular press, has no fixed medical or legal content. The closest thing we have to a medical definition comes from the American College of Obstetricians and Gynecologists (ACOG). The ACOG definition describes a method of abortion (commonly called dilation and extraction, or D&X) involving extraction, from the uterus and into the vagina, of all of the body of a fetus except the head, following which the fetus is killed by extracting the contents of the skull. Thereafter, the dead but otherwise intact fetus is taken from the mother's body. Certainly this medical description is within the definition of "partial-birth abortion" contained in the Nebraska statute before us. The difficulty is that the statute covers a great deal more. It would also prohibit, in many circumstances,

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[3] The Hon. Richard G. Kopf, United States District Judge for the District of Nebraska.

the most common method of second-trimester abortion, called a dilation and evacuation (D&E). Under the controlling precedents laid down by the Supreme Court, such a prohibition places an undue burden on the right of women to choose whether to have an abortion. It is therefore our duty to declare the statute invalid.

I.

On June 9, 1997, Nebraska's Governor signed into law Legislative Bill 23, a bill enacted by the Nebraska Legislature prohibiting "partial-birth abortion." The statute provides:

> No partial-birth abortion shall be performed in this state, unless such procedure is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

Neb. Rev. Stat. § 28-328(1) (1998). "Partial-birth abortion" is defined in the statute as:

> an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. For purposes of this subdivision, the term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows

> will kill the unborn child and does kill the unborn child.

Id. § 28-326(9). The intentional and knowing performance of an unlawful "partial-birth abortion" is a Class III felony. See *id.* § 28-328(2). A physician who intentionally and knowingly performs an unlawful "partial-birth abortion" will automatically have his license to practice medicine in Nebraska suspended and revoked. See *id.* § 28-328(4).

Shortly after the passage of LB 23, Dr. LeRoy Carhart filed a complaint challenging the constitutionality of the statute. In response to the complaint, the District Court granted a temporary restraining order, followed by a preliminary injunction, suspending enforcement of the statute. After a trial on the merits, the District Court issued its final judgment, holding LB 23 unconstitutional, and permanently enjoining enforcement of LB 23 against Dr. Carhart, his patients, and other similarly situated individuals.

Dr. Carhart challenged the constitutionality of LB 23 on two separate grounds. He argued that LB 23 imposed an undue burden on himself and his patients in two ways. First, because the D&X procedure is the safest procedure for some women in certain circumstances, banning that procedure places an undue burden on women seeking an abortion. Second, because LB 23 prohibits vaginally delivering a "substantial portion" of a fetus as part of an abortion procedure, the law bans the dilation and evacuation (D&E) procedure as well. Because the D&E procedure is the most widely used second-trimester abortion procedure, this ban also places an undue burden

on women seeking to have an abortion. Dr. Carhart also challenged the law as being vague, arguing that it was unclear what "substantial portion" meant. The District Court agreed, holding both that the law created an undue burden for Dr. Carhart and his patients, and that the law was void for vagueness. *Carhart v. Stenberg*, 11 F. Supp. 2d 1099 (D. Neb. 1998).[4]

II.

We state the facts as found by the District Court. (The Court's findings are not clearly erroneous, and we therefore must accept them.) Dr. Carhart operates a family medical practice with a specialized abortion facility in Bellevue, Nebraska. He is licensed to practice medicine in Nebraska, as well as in seven other states. Dr. Carhart performs abortions in a clinic setting from a gestational age of three weeks[5] until fetal viability. The abortion procedures Dr. Carhart performs vary depending on the gestational age of the fetus as well as on various other medical factors. As we shall explain, two of the procedures Dr. Carhart performs are directly affected by LB

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[4] Because we are holding the law unconstitutional on undue-burden grounds, it is not necessary for us to discuss the vagueness issue. Nor is it necessary for us to discuss whether the law creates an undue burden by prohibiting the D&X procedure. The basis for our holding is the undue burden created by the ban of the D&E procedure.

[5] Gestational age is measured from the first day of the woman's last menstrual period.

23's ban: dilation and evacuation (D&E) and intact dilation and evacuation or dilation and extraction (D&X).[6] Both are procedures for second-trimester abortions. LB 23 affects not only Dr. Carhart, but any doctor in Nebraska who performs the D&E or the D&X procedure, as well as that doctor's patients.

The most common method of abortion during the second trimester is the D&E procedure. A physician performing a D&E procedure gradually dilates the cervix and then removes the fetus and other products of conception. A report by the American Medical Association[7] describes the D&E procedure used from thirteen to fifteen weeks' gestation as follows:

> Osmotic dilators are usually used. Intravenous fluids and an analgesic or sedative may be administered. A local anesthetic such as a paracervical block may be administered, dilating agents, if used, are removed, and instruments are inserted through the cervix into the uterus to remove fetal and placental tissue. Because fetal tissue is friable and easily broken, the fetus may not be removed intact. The walls of the uterus are scraped with a curette to ensure that no tissue remains. In pregnancies beyond 14 weeks,

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[6] The District Court's very thorough opinion details other abortion procedures as well. We see no need to repeat these descriptions and will therefore focus only on the procedures affected by LB 23.

[7] The parties stipulated to the admission of the American Medical Association's "Report of the Board of Trustees on Late-Term Abortion" at the preliminary injunction hearing. The report, which studied late-term abortion techniques, was admitted as Exhibit 7.

> oxytocin is given intravenously to stimulate the uterus to contract and shrink.

Ex. 7, at 8 (footnotes omitted). The AMA report also includes a description of a D&E procedure used from sixteen to twenty-four weeks' gestation. It includes some variations from the procedure used from thirteen to fifteen weeks. After the cervix has been dilated:

> Fetal tissue is extracted through the use of surgical instruments, followed by extraction of placental tissue and subsequent curettage. Because the fetus is larger at this stage of gestation (particularly the head), and because bones are more rigid, dismemberment or other destructive procedures are more likely to be required than at earlier gestational ages to remove fetal and placental tissue. Some physicians use intrafetal potassium chloride or digoxin to induce fetal demise prior to a late D&E (after 20 weeks), to facilitate evacuation.

Id.

When dismemberment occurs during a D&E procedure, it does not occur in utero. Prelim. Inj. Tr. 116; Trial Tr. 30-31. Dr. Carhart explained that during the D&E procedure, the dismemberment occurs after a part of the fetus has been pulled through the cervix, into the vagina:

> Dr. Carhart: The dismemberment occurs between the traction of . . . my instrument and the counter-traction of the internal os of the cervix. . . .
>
> Counsel: So the dismemberment occurs after you pulled a part of the fetus through the cervix, is that correct?

A: Exactly. Because you're using – The cervix has two strictures or two rings, the internal os and the external os, and you have – that's what's actually doing the dismembering. . . .

Q: When we talked before or talked before about a D&E, that is not – where there is not intention to do it intact, do you, in that situation, dismember the fetus in utero first, then remove portions?

A: I don't think so . . . I don't know of any way that one could go in and intentionally dismember the fetus in the uterus. If you grab an extremity and twist it, you can watch the whole fetus just twist. It takes something that restricts the motion of the fetus against what you're doing before you're going to get dismemberment.

Prelim. Inj. Tr. 116-17. Dr. Phillip Stubblefield, a witness for the plaintiff, testified that to dismember the fetus in utero a physician:

> would have to introduce into the uterus something that would cut up the fetus, or else put in two forceps and try to dismember the fetus inside the uterus, which would increase considerably your chance that you're going to tear the uterus, perforate the uterus, seriously injure the woman. That is not done.

Trial Tr. 31.

In some circumstances, a physician performing a D&E procedure may attempt to remove the fetus intact. This procedure, known as an intact dilation and evacuation (intact D&E) or a dilation and extraction (D&X) can be used in abortions performed from sixteen to twenty-

four weeks' gestation. The AMA report describes the D&X procedure as:

> deliberate dilatation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Ex. 7, at 8 (footnotes omitted). The physician generally brings all of the fetus, except for the head, out of the uterus into the vagina. Trial Tr. 35-36; J.A. 1150. Because the cervix is not dilated enough to allow the head to pass through, the physician inserts an instrument into the fetal skull and evacuates the contents, collapsing the skull and allowing removal of an intact fetus. Trial Tr. 35-36, 716; J.A. 1150.

Fetal death[8] does not always occur at the same stage of each D&E or D&X procedure. Prelim. Inj. Tr. 217-18. In both procedures, the physician brings a part of a living fetus out of the uterus into the vagina.[9] In a D&E procedure, fetal demise will occur after dismemberment. The

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[8] With the use of ultrasound, a physician can detect a fetal heartbeat to determine that a fetus is living. Trial Tr. 22-23. No agreed upon definition exists, however, as to what constitutes fetal demise. *Id.* Physicians determine the death of adults and children by measuring brain function. *Id.* In either a D&E or D&X procedure, any heartbeat or brain function will cease as the procedure progresses. Prelim. Inj. Tr. 113-14, 118-19. The parties to this case seem to agree that a living fetus is one whose heart is beating.

[9] In some cases the fetus is not alive at this stage. In those cases LB 23 would not apply because the abortion procedure

time it takes for fetal demise to occur can, however, vary. *Id.* at 118-19. During a D&X procedure, fetal demise will occur some time after the physician has evacuated the cranial contents. In either procedure, fetal demise will generally occur within a matter of minutes, and after part of the fetus has been brought out of the uterus into the vagina. *Id.* at 112-13, 118-19.

III.

The Supreme Court has held that a woman has a constitutional right to choose whether to terminate a pregnancy. *Roe v. Wade*, 410 U.S. 113, 153 (1973). Although a state cannot prohibit a woman from choosing to have an abortion, the state can promote the interest in potential human life and, after fetal viability,[10] "regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Roe*, 410 U.S. at 164-65. A state can also enact abortion regulations at the pre-viability stage, so long as there is no "undue burden" placed on the woman seeking to have an abortion. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 876 (1992). A regulation which "has the purpose or effect of placing a substantial obstacle in the path of a woman

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would not involve the delivery of a "living" fetus as required by the statute.

[10] As we understand the record and the legal arguments in this case, no question is raised with respect to procedures performed on viable fetuses. The applicable legal standard is therefore the undue-burden rule of *Casey*.

seeking an abortion of a nonviable fetus" creates an undue burden and is invalid. *Id.* at 877.

Several states have enacted statutes seeking to ban "partial-birth abortion." The precise wording of the statutes, and how far the statutes go in their attempts to regulate pre-viability abortions, differ from state to state. The results from constitutional challenges to the statutes, however, have been almost unvarying. In most of the cases that reached the federal courts, the courts have held the statutes unconstitutional.

The Sixth Circuit, the first United States Court of Appeals to consider the issue,[11] struck down an Ohio statute which attempted to ban the D&X procedure. *Women's Medical Professional Corporation v. Voinovich*, 130 F.3d 187, 190 (6th Cir. 1997). The statute specifically

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[11] The Fourth and Seventh Circuits have also heard appeals on this issue. In the Fourth Circuit, Judge Luttig, sitting as a single judge, granted the State of Virginia's stay application after a District Court granted a preliminary injunction enjoining enforcement of the state's partial-birth abortion ban. *Richmond Medical Center for Women v. Gilmore*, 144 F.3d 326, 327 (4th Cir. 1998) (Luttig, J., in chambers). On July 16, 1999, however, after trial on the merits, the District Court struck down the Virginia statute. *Richmond Medical Center for Women v. Gilmore*, No. 3:98CV309 (E.D. Va. Jul. 16, 1999).

The Seventh Circuit reversed a lower court's decision denying Planned Parenthood of Wisconsin's motion for a preliminary injunction against enforcement of a Wisconsin statute banning partial-birth abortion. *Planned Parenthood of Wisconsin v. Doyle*, 162 F.3d 463, 471 (7th Cir. 1998). After a trial on the merits, the District Court upheld the constitutionality of the statute. *Planned Parenthood of Wisconsin v. Doyle*, 44 F. Supp. 2d 975 (W.D. Wis. 1999).

banned only the D&X procedure: "No person shall knowingly perform or attempt to perform a dilation and extraction procedure upon a pregnant woman." Ohio Rev.Code Ann. § 2919.15(B) (1996). The statute defined dilation and extraction as "the termination of a human pregnancy by purposely inserting a suction device into the skull of a fetus to remove the brain." *Id.* § 2919.15(A). The Court held, however, that the statutory definition of the prohibited abortion method included both the D&E and D&X procedures. The D&E procedure sometimes requires a physician to "compress the head by using suction to remove the intracranial contents." *Voinovich*, 130 F.3d at 198. The Court held that because the D&E procedure is the most common method of second-trimester abortions, the statute created an undue burden on women seeking second-trimester abortions. *Id.* at 201. The legislature was aiming at the D&X procedure, but the language of the statute included a definition which encompassed the D&E procedure as well.

A number of district courts have also addressed the constitutionality of state statutes banning "partial-birth abortion." Only one has upheld such a statute. See *Planned Parenthood of Wisconsin v. Doyle*, 44 F. Supp. 2d 975 (W.D. Wis. 1999). The other district courts faced with the issue have all held the statutes unconstitutional. See *Causeway Medical Suite v. Foster*, 43 F. Supp. 2d 604 (E.D. La. 1999) (partial-birth abortion act created substantial obstacle in path of women seeking safe abortion and broad language creating confusion and ambiguity rendered Act unconstitutionally vague); *Planned Parenthood of Central New Jersey v. Verniero*, 41 F. Supp. 2d 478 (D. N.J. 1998) (partial-birth abortion act void for vagueness

because persons of ordinary intelligence must guess at meaning of phrases such as "partially vaginally delivers" and "substantial portion"); *Eubanks v. Stengel*, 28 F. Supp. 2d 1024 (W.D. Ky. 1998) (partial-birth abortion act created undue burden because overbroad language banned procedures necessary to guarantee right to choose to have abortion); *Hope Clinic v. Ryan*, 995 F. Supp. 847 (N.D. Ill. 1998) (partial-birth abortion act void for vagueness because it failed to define conduct proscribed and created undue burden because it had potential effect of banning most common and safest abortion procedures); *Evans v. Kelley*, 977 F. Supp. 1283 (E.D. Mich. 1997) (partial-birth abortion statute vague because ambiguous and susceptible to various interpretations and overbroad because it would operate as substantial obstacle to woman's right to choose to have abortion).

IV.

The District Court in Nebraska joined the majority of the courts that have considered the issue, holding that the statute enacted by the Nebraska Legislature attempting to ban "partial-birth abortion" could not withstand constitutional scrutiny. We review the District Court's conclusions of law de novo. See *Planned Parenthood of Greater Iowa v. Atchison*, 126 F.3d 1042, 1048 (8th Cir. 1997).

In considering a challenge to the facial validity of an abortion regulation, we follow the standard set out in *Casey*. See *Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1458 (8th Cir. 1995). If the regulation operates "as a substantial obstacle to a woman's choice to undergo an abortion 'in a large fraction of the cases in

which [it] is relevant, . . . [i]t is an undue burden, and therefore invalid.' " *Id.* (quoting *Casey*, 505 U.S. at 895).

The District Court determined that LB 23 created an undue burden because in many instances it would ban the most common procedure for second-trimester abortions, the D&E. The State argues that LB 23's ban on partial-birth abortion prohibits only the D&X procedure, and not the D&E. Under the statute, a person is prohibited from "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." Neb. Rev. Stat. § 28-326(9) (1998). The State argues that the Nebraska Legislature's intent was to ban only the D&X procedure. The language of the statute, however, describes a procedure which encompasses more than just D&X.

In interpreting the statute, it is our duty to give it a construction, if reasonably possible, that would avoid constitutional doubts. We cannot, however, twist the words of the law and give them a meaning they cannot reasonably bear. The crucial problem is the term "substantial portion," which is nowhere defined in the statute. What the term means for the purposes of LB 23 has been debated at length, both in the record before us and on the floor of the Nebraska Legislature. But if "substantial portion" means an arm or a leg – and surely it must – then the ban created by LB 23 encompasses both the D&E and the D&X procedures. We agree with the District Court's assessment that "[i]n any sensible and ordinary reading of the word, a leg or arm is 'substantial.' " *Carhart v.*

Stenberg, 11 F. Supp. 2d 1099, 1129 (D. Neb. 1998). In the D&E procedure, the physician often inserts forceps into the uterus, grasps a part of the living fetus, and pulls that part of the fetus through the cervix. That part of the fetus is commonly an arm or a leg. Prelim. Inj. Tr. 117-18; Trial Tr. 31. LB 23 bars intentionally bringing a substantial portion of a living fetus into the vagina for purposes of performing a procedure that will kill the fetus. A physician who brings an arm or a leg into the vagina as part of the D&E procedure therefore violates the statute.

The State argues that the statute's scienter requirement limits the statute's scope. The partial vaginal delivery of a substantial portion of the living fetus must be done "deliberately and intentionally." The statute applies, according to the State, only to the deliberate and intentional performance of a "partial-birth abortion." The State defines the proscribed procedure as involving the intentional "1) partial delivery of a living fetus vaginally, 2) killing the fetus and 3) completing the delivery." Appellant's Br. 66-67. But the D&E procedure involves all three of those steps. The physician intentionally brings a substantial part of the fetus into the vagina, dismembers the fetus, leading to fetal demise, and completes the delivery. A physician need not set out with the intent to perform a D&X procedure in order to violate the statute. It is enough that the physician have the intent to deliver vaginally a substantial portion of a living fetus, and that occurs in the D&E procedure.

Additionally, the person performing the procedure must do so with the purpose of performing a procedure that the person knows "will kill the unborn child and does kill the unborn child." Neb. Rev. Stat. § 28-326(9)

(1998). In any abortion procedure the physician performing the procedure does so knowing, and with the purpose, that the procedure will kill the fetus. The language of LB 23 describes a method of abortion that includes the D&E procedure, and the intent requirement of the statute does not work to protect physicians who perform the D&E procedure from violating the statute LB 23 not only prohibits the D&X procedure, but the D&E procedure as well.

V.

Having determined that LB 23 bans the D&E procedure, we turn now to the question of whether such a ban imposes an undue burden on women seeking second-trimester abortions.

In *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 79 (1976), the Supreme Court held unconstitutional a statute proscribing the use of saline amniocentesis as a method of abortion. Saline amniocentesis was then the most commonly used procedure for abortions performed after the first trimester. *Id.* at 78. By prohibiting the use of the procedure, the statute would effectively inhibit the vast majority of abortions performed after the first trimester. *Id.* at 79. *Danforth* was decided under the trimester framework of *Roe*. Although *Casey* changed that framework, the ban in *Danforth* meets the undue-burden standard of *Casey*. See *Voinovich*, 130 F.3d at 201: "An abortion regulation that inhibits the vast majority of second trimester abortions would clearly have the effect of placing a substantial obstacle in the path of a woman seeking a pre-viability abortion." LB 23 does not

limit all second-trimester abortions. It does, however, prohibit the most common procedure for second-trimester abortions and, in doing so, imposes an undue burden on a woman's right to choose to have an abortion.

VI.

In its final argument, the State suggests that *Roe* and *Casey* do not apply to LB 23 because *Roe* and *Casey* apply only to the "unborn" and do not prohibit states from protecting partially born human beings. The State argues that "the Supreme Court has left protection in place for the partially born." Appellant's Br. 71. The State also suggests that because the partial-birth abortion procedure involves a fetus which is more outside of the uterus than inside, the fetus is not unborn, sufficiently distinguishing this case from *Roe* and *Casey*. The phrase "partially born" is new to us. Apparently the State uses it to describe a process in which the fetus is killed when it is more outside the womb than inside. If we assume that there is such a legal category, and that, as the State argues, the rule of *Roe v. Wade* does not apply to it, the argument is still unavailing on the record before us in this case. As we have explained, the Nebraska statute is violated when an arm or a leg of a fetus that is still alive is pulled out of the womb as part of the D&E abortion procedure. In such a situation, although a substantial part of the fetus, as defined by the Nebraska law, has been extracted from the uterus, it cannot be said that the fetus as a whole is more outside the uterus than inside. In addition, we think that the word "born" refers most naturally to a viable fetus, one that is capable of surviving outside the mother. The Nebraska statute is not limited to viable fetuses. Indeed,

as we have observed, both the proof and the legal arguments in this case seem to be exclusively about nonviable fetuses. So if there is a separate legal category for the "partially born," and we express no view on that question, we do not see how it could be relevant to the present case.

VII.

Mike Munch, in his official capacity as County Attorney for Sarpy County, appeals the District Court's award of attorney's fees against him. After the District Court held LB 23 unconstitutional, Dr. Carhart sought, and was awarded, attorney's fees, pursuant to 42 U.S.C. § 1988. Section 1988 allows a plaintiff who has brought a successful suit under 42 U.S.C. § 1983 to recover, at the court's discretion, reasonable attorney's fees from the defendant. The statute provides that "the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs." 42 U.S.C. § 1988(b) (1994). Because Dr. Carhart was a prevailing party, the District Court appropriately granted his request for attorney's fees.

Mr. Munch is the County Attorney in Sarpy County, the county in which Dr. Carhart practices medicine. Dr. Carhart named Mr. Munch in the lawsuit in his official capacity as Sarpy County Attorney and as a representative of all county attorneys in Nebraska. Mr. Munch agrees that Dr. Carhart was a prevailing party. He argues, however, that the award of attorney's fees should not apply against him. We review the award of attorney's fees

for an abuse of discretion. See *Hatfield v. Hayes*, 877 F.2d 717, 719 (8th Cir. 1989).

A prevailing party in a § 1983 suit "should ordinarily recover an attorney's fee unless special circumstances would render such an award unjust." *Id.* According to Mr. Munch, the special circumstances in this case are that as a government official he is bound to follow state law and enforce LB 23, and that he did not actively participate in the lawsuit. The short answer is that governmental officials are not bound to follow state law when that law is itself unconstitutional. Quite the contrary: in such a case, they are bound *not* to follow state law. It is true that a prosecuting attorney may not know for certain whether a state law is valid or not, and that he may feel obliged to enforce the law until a determination as to its validity has been made. This, however, is not a special circumstance justifying the denial of the customary award of fees. Presumably it will always be true that state officials enforcing a law or otherwise defending state action will believe, or at least hope, that the law or action in question will be upheld against a federal constitutional attack. The point of § 1988 is that such officials proceed at their peril. If in fact they are wrong, and the law they are enforcing turns out to be invalid, § 1988 puts the financial burden on the state officials. The judgment of Congress is that the burden rests more properly on them than on the party who has been wronged by the application of an invalid law.

In addition, although Mr. Munch has not had the opportunity to enforce LB 23, he has made it clear that he would prosecute under the statute. J.A. 646-47. Awarding fees against officials bound to enforce the law is a "run-

of-the-mill occurrence[ ]." *Supreme Court of Virginia v. Consumers Union of the United States*, 446 U.S. 719, 739 (1980). Additionally, Mr. Munch has the discretion to choose when to prosecute. We find no merit in this argument.

Mr. Munch's argument that he did not actively participate in the lawsuit and that he should not, therefore, be responsible for the attorney's fees, is equally without merit. His role in the proceedings may have been minor, but this does not excuse him from having to share in the actual costs. He relied on his co-defendants to present their defense of the constitutionality of LB 23, a statute he has indicated he would enforce, and he cannot now avoid helping to pay the prevailing party's attorney's fees.

The District Court did not abuse its discretion in holding Mr. Munch liable, jointly and severally with the other defendants, for the attorney's fee award. How the defendants choose to allocate the fees among themselves is entirely up to them.

VIII.

For the foregoing reasons, we affirm the judgment of the District Court.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT.

In the
United States Court of Appeals
for the Seventh Circuit

No. 98-1726
THE HOPE CLINIC, *et al.*,

Plaintiffs-Appellees,

v.

JAMES E. RYAN, Attorney General of Illinois, and RICHARD K. DEVINE, State's Attorney of Cook County, Illinois,

Defendants-Appellants.

Appeal from the United States District Court for the Northern District of Illinios, Eastern Division. No. 97 C 6702 – Charles P. Kocoras, *Judge*.

Nos. 99-2528 & 99-2533
DENNIS D. CHRISTENSEN, *et al.*,

Plaintiffs-Appellants,

v.

JAMES E. DOYLE, Attorney General of Wisconsin, and DIANE M. NICKS, District Attorney for Dane County, Wisconsin,

Defendants-Appellees.

Appeals from the United States District Court for the Western District of Wisconsin. No. 98-C-0305-S – **John C. Shabaz**, *Chief Judge*.

ARGUED SEPTEMBER 22, 1999 – DECIDED OCTOBER 26, 1999

Before POSNER, *Chief Judge*, and COFFEY, FLAUM, EASTERBROOK, MANION, KANNE, ROVNER, DIANE P. WOOD, and EVANS, *Circuit Judges*.*

EASTERBROOK, *Circuit Judge*. We must decide whether state laws prohibiting partial-birth abortions are unconstitutionally vague or unduly burden women's rights. Acting without an evidentiary hearing, a district court held the Illinois statute unconstitutional and entered a permanent injunction. *Hope Clinic v. Ryan*, 995 F.Supp. 847 (N.D. Ill. 1998). But after a trial, another district court concluded that the Wisconsin statute is valid. *Planned Parenthood of Wisconsin v. Doyle*, 44 F.Supp.2d 975 (W.D. Wis. 1999). A panel of this court earlier had ordered preliminary relief against Wisconsin's law, see *Planned Parenthood of Wisconsin v. Doyle*, 162 F.3d 463 (7th Cir. 1998), and plaintiffs say that this decision, applying *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), justifies permanent injunctions against both states' rules. To ensure consistency, we heard the appeals en banc. We conclude that both laws can be applied in a constitutional manner. *Whether* that will occur depends on state courts, which alone can settle questions about the construction of the statutes. To ensure that physicians are not deterred from performing other medical procedures while issues wend their way through state tribunals, we hold that both sets of plaintiffs are entitled to injunctive relief that will limit the

* Circuit Judge Ripple did not participate in the consideration or decision of these cases.

statutes' application to the medical procedure that each state insists is its sole concern.

I

Induction, suction curettage, and dilation and evacuation (D & E) are the principal methods of performing abortions in the United States. Prohibiting any one of these would conflict with the right of abortion recognized by cases such as *Casey*, 505 U.S. at 877 (plurality opinion) (adopting "undue burden" as the constitutional standard), and *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 75-79 (1976) (holding that a state may not forbid saline amniocentesis, at the time the principal means of induction). Our cases involve an uncommon procedure known to the medical community as "intact dilation and extraction" or just "dilation and extraction (D & X)," and to the public as "partial-birth abortion."

Some medical background is essential to understanding the issues. Induction means inducing preterm labor, which causes the expulsion of the conceptus. Methotrexate or mifepristone (RU-486, now in clinical trials), in combination with misoprostol, can be used for this purpose early in pregnancy; saline amniocentesis and injected prostaglandins serve the same function in the second trimester. Suction curettage (vacuum aspiration), the most common surgical method of abortion early in pregnancy, refers to evacuation of the uterine cavity; the embryo or fetus is separated from the placenta either by scraping or vacuum pressure, then is removed by suction. When these methods are inappropriate, or do not work, physicians employ the D & E procedure. To perform a D

& E, the physician dilates the cervix and dismembers the fetus inside the uterus using forceps. Fetal parts are removed with forceps or by suction.

A D & X is a variant of a D & E in which the fetus is removed without dismemberment. The American College of Obstetricians and Gynecologists (ACOG) defines D & X as follows: "1. deliberate dilatation of the cervix, usually over a sequence of days; 2. instrumental conversion of the fetus to a footling breech; 3. breech extraction of the body excepting the head; and 4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus." Martin Haskell, the physician who developed the D & X procedure, see *Dilation and Extraction for Late Second Trimester Abortion* (1992), reprinted in 139 Cong. Rec. E1092 (Apr. 29, 1993), believes that how the head is diminished in size so that it can pass through the cervix is not important: mechanically crushing the skull serves the same end as evacuating its contents, which causes its collapse. It is this combination of coming so close to delivering a live child with the death of the fetus by reducing the size of the skull that not only distinguishes D & X from D & E medically but also causes the adverse public (and legislative) reaction. Opponents deem the D & X procedure needlessly cruel and bordering on infanticide, and all three states in this circuit have enacted statutory restrictions.

The statute in Illinois has three sections with legal significance:

720 ILCS § 513/5. Definitions

In this Act: "Partial-birth abortion" means an abortion in which the person performing the abortion partially vaginally delivers a living human fetus or infant before killing the fetus or infant and completing the delivery. The terms "fetus" and "infant" are used interchangeably to refer to the biological offspring of human parents.

720 ILCS § 513/10. Partial-birth abortions prohibited

Any person who knowingly performs a partial-birth abortion and thereby kills a human fetus or infant is guilty of a Class 4 felony. This Section does not apply to a partial-birth abortion that is necessary to save the life of a mother because her life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering condition caused by or arising from the pregnancy itself, provided that no other medical procedure would suffice for that purpose.

720 ILCS § 513/15. Civil action

The maternal grandparents of the fetus or infant, if the mother has not attained the age of 18 years at the time of the abortion, may in a civil action obtain appropriate relief unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion. The relief shall include money damages for all injuries, psychological and physical, occasioned by the violation of this Act and statutory damages equal to 3 times the cost of the partial-birth abortion.

The Indiana statute defines "partial-birth abortion" in identical terms. Ind. Code § 16-18-2-267.5. Like Illinois it forbids partial-birth abortions unless that procedure is necessary to save the mother's life, and no other procedure would suffice. Ind. Code § 16-34-2-1(b). The Indiana statute has never been challenged and has been in effect since July 1, 1997.

Wisconsin has taken a slightly different approach. Its statutes provide:

> Wis. Stat. § 895.038 Partial-birth abortions; liability.
>
> (1) In this section:
>
> (a) "Child" has the meaning given in § 940.16 (1)(a).
>
> (b) "Partial-birth abortion" has the meaning given in § 940.16 (1)(b).
>
> (2)(a) Except as provided in par. (b), any of the following persons has a claim for appropriate relief against a person who performs a partial-birth abortion:
>
> 1. If the person on whom a partial-birth abortion was performed was a minor, the parent of the minor.
>
> 2. The father of the child aborted by the partial-birth abortion.
>
> (b) A person specified in par. (a) 1. or 2. does not have a claim under par. (a) if any of the following apply:
>
> 1. The person consented to performance of the partial-birth abortion.

> 2. The pregnancy of the woman on whom the partial-birth abortion was performed was the result of a sexual assault in violation of § 940.225, 944.06, 948.02, 948.025, 948.06 or 948.09 that was committed by the person.
>
> (3) The relief available under sub. (2) shall include all of the following:
>
> (a) If the abortion was performed in violation of § 940.16, damages arising out of the performance of the partial-birth abortion, including damages for personal injury and emotional and psychological distress.
>
> (b) Exemplary damages equal to 3 times the cost of the partial-birth abortion.
>
> (4) Subsection (2) applies even if the mother of the child aborted by the partial-birth abortion consented to the performance of the partial-birth abortion.
>
> Wis. Stat. § 940.16 Partial-birth abortion. (1) In this section:
>
> (a) "Child" means a human being from the time of fertilization until it is completely delivered from a pregnant woman.
>
> (b) "Partial-birth abortion" means an abortion in which a person partially vaginally delivers a living child, causes the death of the partially delivered child with the intent to kill the child, and then completes the delivery of the child.
>
> (2) Except as provided in sub. (3), whoever intentionally performs a partial-birth abortion is guilty of a Class A felony.

> (3) Subsection (2) does not apply if the partial-birth abortion is necessary to save the life of a woman whose life is endangered by a physical disorder, physical illness or physical injury, including a life-endangering physical disorder, physical illness or physical injury caused by or arising from the pregnancy itself, and if no other medical procedure would suffice for that purpose.

Wisconsin's definition of partial-birth abortion is substantially the same as Illinois', but the mental-state elements differ, as do the maximum penalties: Illinois makes unjustified partial-birth abortion a Class 4 felony, with a maximum penalty of three years; in Wisconsin the offense is a Class A felony, for which Wis. Stat. § 939.50(3)(a) provides a penalty of life imprisonment.

Because Wisconsin and Illinois use similar language to define partial-birth abortions, we illustrate plaintiffs' concerns with the latter's statute:

> "Partial-birth abortion" means an abortion in which the person performing the abortion partially vaginally delivers a living human fetus or infant before killing the fetus or infant and completing the delivery. The terms "fetus" and "infant" are used interchangeably to refer to the biological offspring of human parents.

This legal definition is an imperfect match for the medical definition of D & X. It is easy to see why a legislature would be chary of the ACOG's specification: then any small variation (such as a change in the method of reducing the head size, or snipping off a toe to defeat the "otherwise intact" specification) would take the abortion outside the prohibition, even though the reasons why the

technique has been deemed objectionable would be unaffected. But, as is common with legislation, the price of avoiding loopholes is generality. Section 513/5 captures the idea, central to the D & X procedure, that an intact fetus moves from uterus to vagina before death occurs. But it also uses the words "delivers" and "delivery," which many physicians understand to refer to any removal of fetal material from the uterus. The law might be read to prohibit the extraction of dismembered parts following a D & E, or to prohibit abortion by induction if by chance the fetus survives until it reaches the birth canal. Moreover, physicians performing a D & E sometimes do not complete the dismemberment inside the uterus, and some fear that this could lead the procedure to be characterized as a partial delivery under the statute.

The possibility that § 513/10 might discourage risk-averse physicians from performing the D & E procedure led the district court in Illinois to declare that it is too vague to be enforced, and a similar concern animated our panel's decision to require preliminary relief against Wisconsin's law. Moreover, if these laws needlessly raise the effective costs of induction, suction curettage, or D & E, then they would unduly burden the right of abortion, another concern expressed not only by the district court in the Illinois case but also by the panel in the Wisconsin case. But after a trial on remand, the district court in Wisconsin concluded that physicians who perform abortions recognize that the statutory formula, however vague or broad these words appear to lay eyes, refers to the D & X procedure alone. The court held that, as so limited, the statute does not substantially burden any

woman's right to an abortion, because D & X is never the only safe procedure.

Litigation elsewhere has produced results mirroring the divergence between the outcomes in Illinois and Wisconsin. The sixth circuit held that Ohio's ban on partial-birth abortions is unconstitutional, *Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187 (6th Cir. 1997), but the fourth circuit issued a stay preventing interference with Virginia's statute. *Richmond Medical Center for Women v. Gilmore*, 144 F.3d 326 (4th Cir. 1998), motion to vacate stay denied, 1998 U.S. App. LEXIS 18547. Both of those decisions were rendered over dissents. A single panel of the eighth circuit recently held three states' partial-birth-abortion laws unconstitutional, but only after first concluding that all three statutes forbid the D & E procedure. *Carhart v. Stenberg*, 1999 U.S. App. LEXIS 23162 (8th Cir. Sept. 24, 1999) (Nebraska); *Little Rock Family Planning Services, P.A. v. Jegley*, 1999 U.S. App. LEXIS 23165 (8th Cir. Sept. 24, 1999) (Arkansas); *Planned Parenthood of Greater Iowa, Inc. v. Miller*, 1999 U.S. App. LEXIS 23166 (8th Cir. Sept. 24, 1999) (Iowa).

II

Plaintiffs would like us to employ the approach of our panel's opinion in the Wisconsin case and declare both states' laws unconstitutional without ado. But different statutes have different language, which may be important. Litigants also have made distinctive arguments – for example, Illinois relies on *United States v. Salerno*, 481 U.S. 739, 745 (1987), for the proposition that, except in first amendment cases, a law may be held

unconstitutional only when "no set of circumstances exists under which the Act would be valid." Moreover, two events since the panel wrote call for fresh analysis. First, that opinion dealt with preliminary relief and observed that "the full trial may cast the facts in a different light". 162 F.3d at 466. That trial has been held in Wisconsin, and its results must be considered. Second, both the panel's decision in the Wisconsin case and the district court's opinion in the Illinois case conclude that the statute *as written* is vague. A more recent decision of the Supreme Court, *Chicago v. Morales*, 119 S. Ct. 1849 (1999), stresses that state courts are entitled to construe state laws to reduce their ambiguity, and that federal courts should evaluate state laws as they have been construed, not just as they appear in the statute books. See also, e.g., *Parker v. Levy*, 417 U.S. 733 (1974); *Civil Service Commission v. Letter Carriers*, 413 U.S. 548 (1973). This implies that Illinois and Wisconsin are entitled to interpret their own laws – that federal courts should not enjoin all application before enforcement and thus prevent the state courts from having a chance to save their statutes.

Salerno offers a potential ground for giving the states that chance. It would be hard to say that every possible instance of the D & X procedure is protected by the Constitution. Along similar lines are the many cases saying that outside the domain of the first amendment, vagueness challenges must be assessed "as applied." See, e.g., *Maynard v. Cartwright*, 486 U.S. 356, 361 (1988); *Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 494-95 (1982). But we are reluctant to rely too heavily on this approach, because *Morales* shows that three Justices

believe that this language is too sweeping, see 119 S. Ct. at 1858-59 & n.22 (Stevens, J., joined by Souter & Ginsburg, JJ.), and the Supreme Court has on occasion resolved constitutional challenges to statutes that do not involve speech without asking whether every conceivable application would be unconstitutional. E.g., *Romer v. Evans*, 517 U.S. 620 (1996); *Kolender v. Lawson*, 461 U.S. 352, 358-59 n.8 (1983); *Nash v. United States*, 229 U.S. 373 (1913). Only one Justice offered any support for *Salerno*'s approach in *Morales*, and he did so in a dissenting opinion. 119 S. Ct. at 1867-72 (Scalia, J., dissenting). Justice Scalia identified many cases that articulate *Salerno*'s requirement, and many others that bypass the inquiry. Courts of appeals are divided on the question whether *Salerno* applies to abortion legislation. Compare *Jane L. v. Bangerter*, 102 F.3d 1112, 1116 (10th Cir. 1996), with *Barnes v. Moore*, 970 F.2d 12, 14 n.2 (5th Cir. 1992). The safest course for a court of appeals, when confronted with inconsistent lines of precedent, is to decide on other grounds if at all possible. Here it is possible, for we think that the Supreme Courts of Illinois and Wisconsin could read their laws in ways that comport with the Constitution.

1. One means of doing this would be to assimilate the statutory definitions to the medical definition of D & X, with allowance for different ways of reducing the head size and other immaterial variations. Both states are concerned about the D & X procedure and did not set out to forbid any other. The Attorneys General of Illinois and Wisconsin, the principal defendants, tell us that their statutes are concerned only with the D & X procedure and will be enforced only against its use. That assurance

might be enough by itself, in the absence of any contrary indication from the state judiciary, to resolve immediate vagueness concerns. See *Frisby v. Schultz*, 487 U.S. 474, 483 (1988); cf. *Arizonans for Official English v. Arizona*, 520 U.S. 43, 76-80 (1997). Although local prosecutors (States' Attorneys in Illinois, District Attorneys in Wisconsin) initiate criminal prosecutions, representatives of these prosecutors have been named as parties in each case, and they agree with the Attorneys General. Plaintiffs object that this approach would rewrite rather than interpret the law, but we doubt this. Both medical and popular literature equate "partial-birth abortion" (the statutory term) with the D & X procedure. See Janet E. Gans Epner, Harry S. Jonas & Daniel L. Seckinger, *Late-term Abortion*, 280 J. Am. Medical Ass'n 724 (Aug. 26, 1998); M. LeRoy Sprang & Mark G. Neerhof, *Rationale for Banning Abortions Late in Pregnancy*, 280 J. Am. Medical Ass'n 744 (Aug. 26, 1998). The district court in Wisconsin found that this is the statute's aim. 44 F.Supp.2d at 984 (relying on the Attorney General's concession). Using a medical definition to supplement a vague lay definition does not strike us as revisionism or an exercise in deconstruction.

But if this approach would nonetheless be an example of brute force used to save a statute – well, courts do it all the time. Florida had a law forbidding "the abominable and detestable crime against nature". Placement in the code showed that this crime had something to do with sex, but what? Did it forbid incest? Necrophilia? Bestiality? A legal historian might give an answer, but to lay readers of the statute, and even to most lawyers, the words are Delphic. The state's highest court filled in the blank by saying that the object was sodomy – and the

Supreme Court of the United States rebuffed a charge of unconstitutional vagueness, given the state court's prestidigitation. *Wainwright v. Stone*, 414 U.S. 21 (1973). Only if vagueness remains *after* judicial interpretation is there a constitutional problem, the Court held. See also, e.g., *United States v. Lanier*, 520 U.S. 259 (1997); *Rose v. Locke*, 423 U.S. 48 (1975); *Lanzetta v. New Jersey*, 306 U.S. 451, 455-57 (1939); *Kolender*, 461 U.S. at 355-57. Federal courts have performed equally dramatic feats. As written, the Federal Election Campaign Act is hopelessly vague and overbroad. *Buckley v. Valeo*, 424 U.S. 1 (1976), saved the bulk of the statute by adding details. In two recent cases we predicted that state courts would follow suit with comparable state laws. See *Wisconsin Right to Life, Inc. v. Paradise*, 138 F.3d 1183 (7th Cir. 1998); *Brownsburg Area Patrons Affecting Change v. Baldwin*, 137 F.3d 503 (7th Cir. 1998). In the latter case, because we were not completely confident that the state judiciary would follow *Buckley's* path of freewheeling interpretation, we certified the issue to the Supreme Court of Indiana – which responded that it indeed possesses, and is inclined to use, that power. *Brownsburg Area Patrons Affecting Change v. Baldwin*, 714 N.E.2d 135 (Ind. 1999).

Relying on *Colautti v. Franklin*, 439 U.S. 379 (1979), the sixth circuit concluded in *Women's Medical Professional Corp. v. Voinovich* that any statute concerning abortion is unconstitutionally vague, no matter how precise an interpretation state courts eventually develop, unless it requires proof that the physician knows that a given act has been forbidden. If this were so, then the approach to avoiding vagueness that we have just sketched would be untenable. But it is not so; never has the Supreme Court

held that all criminal laws (or even just all criminal laws affecting abortion) depend on scienter. Cases we have mentioned already (and more that we cite later) hold that a statute may be sustained against a charge of vagueness if, as construed, it gives reasonable notice of the forbidden conduct. That the notice does not sink in – that some people close their eyes (or minds) and thus do not learn of the law's contents or appreciate its application to their conduct – does not prevent a state from enforcing its rules. See *United States v. Wilson*, 159 F.3d 280, 288-89 (7th Cir. 1998). This subject received sustained attention in *Karlin v. Foust*, 188 F.3d 446, 460-64 (7th Cir. 1999). For the reasons laid out in *Karlin* we respectfully disagree with the sixth circuit's understanding of this question. See also Note, 112 Harv. L.Rev. 731 (1999) (criticizing *Women's Medical Professional Corp.*).

2. Although the Constitution does not compel states to ameliorate vagueness problems by using a mental-state requirement to limit prosecutions to situations in which the defendant knows that his acts are forbidden, they are free to do so. This is the path the Supreme Court took in *Screws v. United States*, 325 U.S. 91 (1945), and *United States v. Kozminski*, 487 U.S. 931 (1988), to save 18 U.S.C. §§ 241 and 242. These companion statutes, the poster children for a vagueness campaign, make it a crime to deprive anyone of any constitutional right (or conspire to do so). These statutes are written entirely in terms that have been difficult to pin down, such as "under color of any law" and "rights, privileges, or immunities secured or protected by the Constitution . . . of the United States". Section 242 contains the word "willfully", and in *Screws* the Court read this to mean that a person commits the

offense only if he *knows* that his acts deprive someone of a constitutional right. A person who actually recognizes his legal obligation can't complain that he lacked notice. Many cases since *Screws* use a knowledge requirement to prevent unfair surprise when the statute is vague or complex. E.g., *Cheek v. United States*, 498 U.S. 192 (1991) (tax laws); *Staples v. United States*, 511 U.S. 600 (1994) (gun-control laws).

Both Illinois and Wisconsin put mental-state elements in their statutes. Attorneys General of both states contend that under their laws a procedure may be deemed a "partial-birth abortion" only if at the outset of the procedure the physician intends to perform all of the steps that mark the D & X. We think that the Supreme Courts of both states could go even farther and read the statutes to require knowledge of the legal rules, and thus to follow the trail blazed in *Screws*.

The critical language in Illinois reads: "Any person who *knowingly* performs a partial-birth abortion and thereby kills a human fetus or infant is guilty of a Class 4 felony." 720 ILCS § 513/10 (emphasis added). If the Supreme Court of Illinois reads "knowingly" in § 513/10 the same way the Supreme Court of the United States read "willfully" in § 242, then there is no vagueness problem with § 513/10. And we can't see any impediment to giving "knowingly" such a reading. In context, the word sounds distinctly like a requirement that the physician know that the medical procedure being performed is a "partial-birth abortion" and not simply that the physician know that he is performing particular physical acts. The most natural reading is one that requires

knowledge of the law's application to the medical procedure being performed. Federal courts have been creative with knowledge requirements as a means of saving statutes against constitutional infirmity. E.g., *United States v. X-Citement Video, Inc.*, 513 U.S. 64 (1994). Section 513/10 readily supports a construction that eliminates all concern about vagueness, which makes it inappropriate for a federal court to enjoin its application. (In *Morales*, the Supreme Court's most recent vagueness opinion, the lead opinion stressed that the statute lacked any mental-state requirement.)

Wisconsin uses the word "intentionally" rather than the word "knowingly." Its statute has two intent elements: a partial-birth abortion is defined as one in which the physician acts with "the intent to kill the child", Wis. Stat. § 940.16(1)(b), and the section defining the offense reads: "[W]hoever intentionally performs a partial-birth abortion is guilty of a Class A felony." Wis. Stat. § 940.16(2). The reference to "intent" in § 940.16(1)(b) must mean "that the actor either has a purpose to do the thing or cause the result specified, or is aware that his or her conduct is practically certain to cause that result." Wis. Stat. § 939.23(4) (defining "with intent to"). The reference to "intentionally" in § 940.16(2) has at least potentially a broader scope. Although § 939.23(3) defines "intentionally" as "a purpose to do the thing or cause the result specified", a "partial-birth abortion" is neither a thing nor a result; it is a defined legal term. It is therefore a distinct possibility that the Supreme Court of Wisconsin will read this reference as equivalent to "wilfully" or "knowingly" notwithstanding the caution in § 939.23(5) that criminal intent "does not require proof of knowledge

of the . . . scope or meaning of the terms used in" a statute. The question here is not whether a physician understands the terms of § 940.16(1)(b) in the abstract, but whether the physician intends that the plan of action add up to a "partial-birth abortion." In cases such as *X-Citement Video*, *Cheek*, and *Staples*, the Supreme Court of the United States was exceptionally creative with statutory allusions to mental states; plaintiffs have not established that the Supreme Court of Wisconsin would be unwilling to save its statutes the way the Supreme Court of the United States saved 18 U.S.C. § 242.

3. Still a third interpretive approach is open to the state courts. They may elect to apply the statute to its central core of meaning, the D & X, while working out in common law fashion its outer boundaries. See *United States v. Pitt-Des Moines, Inc.*, 168 F.3d 976, 986-90 (7th Cir. 1999). This is how the Supreme Court has chosen to proceed with respect to the Sherman Antitrust Act, 15 U.S.C. §§ 1, 2, a statute much less precise than the partial-birth-abortion laws. Long before the development of a body of antitrust rules, or even of a clear distinction between the domains of the per se rule and the rule of reason, the Court rebuffed a vagueness challenge, remarking that "law is full of instances where a man's fate depends on his estimating rightly, that is, as the jury subsequently estimates it, some matter of degree." *Nash*, 229 U.S. at 377 (Holmes, J.). The Court took the same approach in *Parker v. Levy for Article 133 of the Uniform Code of Military Justice*, which makes it a crime for a commissioned officer to engage in "conduct unbecoming an officer and a gentleman." That statute, compared to

which § 513/5 and § 940.16(1)(b) are paragons of specificity, was sustained against a vagueness challenge because the military courts had added details over many years, and the Supreme Court anticipated that they would continue to do so as new situations arose. *Letter Carriers* applies the same approach to vague provisions of the Hatch Act. *Parker* cannot be passed off as a sport of military law; it is just one illustration of the proposition that vagueness may be overcome incrementally, as well as by an all-at-once construction. Consider *United States v. Powell*, 423 U.S. 87 (1975), a civilian case dealing with 18 U.S.C. § 1715, which makes it a crime to mail a firearm capable of being concealed on the person. A Derringer unquestionably qualifies, and although larger guns pose tough questions, the combination of a core meaning plus size as a metric for adjudication enabled the Court to hold that borderline cases could be decided later, as they arose.

Notice the difference between this approach and *Salerno*. In cases such as *Nash*, *Parker*, and *Powell*, the Court did not ask simply whether there was one constitutional application. It asked whether there was a core of meaning that people could grasp. In *Nash* the common law of restraint of trade supplied that core; in *Parker* the accumulated body of military precedents did so; in *Powell* the core comprised handguns. Occasionally the Court fortifies this approach by combining it with a *scienter* requirement, as *United States v. United States Gypsum Co.*, 438 U.S. 422 (1978), did for the Sherman Act. Illinois and Wisconsin can follow the same path. For their statutes, the medical definition of the D & X procedure supplies

the core of understandable application. Indeed, the district court in Wisconsin found as a matter of fact that physicians who are likely to perform an abortion already understand that this is the point of partial-birth-abortion statutes. 44 F.Supp.2d at 978. That finding cannot be set aside as clearly erroneous.

Plaintiffs respond to this core-plus-common-law approach by contending that a statute is unconstitutionally vague until the interstices have been filled in. But then all of the cases we have cited were wrongly decided, for the interstices of antitrust law were not filled in by 1913, nor were all of the gun-mailing issues worked out before 1975: *Powell* involved a sawed-off shotgun, not a pistol. To say that the law cannot be applied to anyone, even a person who commits a violation within the core of the statute, until all issues about its reach have been resolved would prevent those issues from coming before the court to be resolved. How, precisely, are the interpretive wrinkles to be smoothed if the law can't be invoked? By advisory opinions? Anyway, there is always a periphery, no matter how many situations judges have evaluated. Resolving each new question moves the area of uncertainty but can't abolish it. "Whenever the law draws a line there will be cases very near each other on opposite sides. The precise course of the line may be uncertain, but no one can come near it without knowing that he does so, if he thinks, and if he does so it is familiar to the criminal law to make him take the risk." *United States v. Wurzbach*, 280 U.S. 396, 399 (1930) (Holmes, J.).

Protection for events outside the core is provided by the principle that surprising and unanticipated applications of a criminal statute violate the due process clause.

See, e.g., *Bouie v. Columbia*, 378 U.S. 347, 351 (1964); *Marks v. United States*, 430 U.S. 188, 196 (1977); *Lanier*, 520 U.S. at 266. Given the assurances made in this litigation by the Attorneys General of Illinois and Wisconsin, application of these states' partial-birth-abortion statutes to a normal D & E or induction (including one that began as a D & E but turned out to have elements of a D & X because of inadvertence or developments during surgery) would be surprising and constitutionally impermissible. Plaintiffs therefore can practice medicine without undue concern on the legal front. The Constitution provides the assurance they crave – but without the need to prevent application of the state law to the D & X procedure itself. States have a powerful interest in working out the details of their criminal laws in their own courts. See *Younger v. Harris*, 401 U.S. 37 (1971); *Nelson v. Murphy*, 44 F.3d 497 (7th Cir. 1995). On remand the district judges should enter precautionary injunctions, limited to implementing the conclusion of this paragraph that the state laws may not be applied to a normal D & E or induction until after the state has provided additional specificity, by statutory amendment, regulations, or judicial interpretation (which could arise either from civil litigation, see Part IV below, or from criminal prosecutions in which the parties disagree about whether the medical procedure properly may be labeled a D & X). With that assurance in hand, plaintiffs would not face any *substantial* threat of prosecution.

A skeptic might respond: what's the basis for an injunction without a finding of actual constitutional violation? The basis is the risk that plaintiffs face. See *Ex parte Young*, 209 U.S. 123 (1908). Whenever suit is brought against a statute that has yet to be enforced, there is a

chance that what the federal court does will be unnecessary or even advisory – for in the absence of relief the statute might *never* be enforced in a way that plaintiffs fear, or that would violate their rights. Everything depends on probabilities. Plaintiffs believe that the probability of improper prosecution is so high that the statutes must be enjoined root and branch. We think that the probability of improper prosecution is low, but non-zero; and a prosecution for performing a D & E not only raises vagueness concerns but also could unduly burden women's rights (see Part III below). That risk can be reduced to a constitutionally acceptable level with a simple injunction based on *Bouie*.

Persons who believe that the risk of improper prosecution is so high that *all* prosecution under the statute should be enjoined are poorly situated to contend that the risk also is so low that the plaintiffs lack standing under *Los Angeles v. Lyons*, 461 U.S. 95 (1983). When this case began the plaintiffs faced a real risk and therefore had standing; and no one thinks that defendants' representations about their projected course of enforcement have made the controversy moot. If as plaintiffs believe the Constitution requires an injunction against everything Illinois and Wisconsin have enacted, *despite* these assurances, then the Constitution can't simultaneously forbid an injunction against potential misuses of state power in the enforcement of these laws. Article III does not limit a federal court's choice to enjoining nothing, or enjoining everything. The path we choose allows the states to interpret their laws and supply more concrete rules, see *Bellotti v. Baird*, 428 U.S. 132, 146-47 (1976); the path the plaintiffs (and our dissenting colleagues) prefer would

foreclose now and forever all interpretation by the state judiciary. By filing suit against a novel and ambiguous law in federal court, litigants can't preclude interpretation by the state judiciary. Our precautionary approach preserves the state judiciary's role while protecting plaintiffs' (and their patients') legitimate interests in the interim.

4. In the Wisconsin case our panel expressed concern that even if the probability of unanticipated application is low, the penalty is so high (life imprisonment) that physicians would avoid performing the D & E procedure. 162 F.3d at 469. This cannot be said of Illinois, where the maximum penalty is three years' imprisonment. Although the threat of life in prison has a greater potential to induce caution than does the threat of three years in prison, the precautionary injunction discussed above should reduce the risk of improper or unanticipated application to a trivial level. The right constitutional objection to a Draconian penalty is not vagueness (a statute's scope is equally clear or uncertain whether the penalty is a $10 fine or 20 years in prison) but a contention that severe criminal punishment for a medical misunderstanding would inflict cruel and unusual punishment. Plaintiffs themselves do not make such an argument, however; they object to the substance of the state laws, not to the punishment available on conviction. The penalty is an afterthought, scarcely mentioned in their briefs. If Wisconsin should some day impose a lengthy prison term for a violation of § 940.16(2), then it will be time to consider arguments based on the eighth amendment.

5. For the last two years, a natural experiment has been conducted in the United States. Thirty states enacted laws forbidding most partial-birth abortions. Judges prohibited the application of these laws in two-thirds of these states; in the other third the statutes have been in force. One way to perform a reality check on the district court's conclusion in the Wisconsin case that physicians know that these statutes cover only the D & X is to see what has happened in the states where the laws have been permitted to take effect. Vagueness could affect physicians in either or both of two ways. First, they might send women seeking second-trimester abortions to other states that do not regulate partial-birth abortions. The result would be a decrease in second-trimester abortions as a percentage of all abortions in the state. Second, physicians might select a different procedure – principaily substituting induction for a D & E – even though the replacement was medically inferior. This would produce a change in the ratio of inductions to D & E procedures in the affected state.

Indiana supplies a nice test, because its law took effect on July 1, 1997, so it is easy to compare the first six months of 1997 to the second six. Moreover, Indiana is surrounded by states that lack an effective prohibition on partial-birth abortions (because of the Illinois injunction and the sixth circuit's ruling in *Women's Medical Professional Corp.*), so it was relatively easy for physicians to send their patients elsewhere. Although the maximum penalty in Indiana is not steep (an unjustified partial-birth abortion there is a Class C felony, Ind. Code § 16-34-2-7(a), for which the punishment is four years' imprisonment, Ind. Code § 35-50-2-6(a)), no state or federal court has construed the statutory term, so whatever uncertainty the raw text of the statute engenders is unabated.

During 1997 a total of 13,208 abortions were performed in Indiana. (These data come from tables prepared by Indiana's State Epidemiologist.) During the first six months, 74 late-second-trimester abortions were performed: 72 by D & E and 2 by intra-uterine prostaglandin injection. During the second six months (that is, after the partial-birth-abortion law took effect), 87 late-second-trimester abortions were performed, all by D & E. Thus physicians did *not* substitute induction for D & E in order to reduce risk to themselves. Nor did they avoid the D & E procedure by sending women to other states. Abortion by D & E during the first six months represented 1.03% of all abortions performed in Indiana (72 of 6,950). Abortion by D & E during the second six months represented 1.39% of all abortions in the state (87 of 6,258). These data are incompatible with plaintiffs' *a priori* belief that the partial-birth-abortion statutes will discourage the performance of the D & E procedure or cause the physician to substitute an inferior procedure. Perhaps things have turned out differently in other states, or perhaps physicians behaved differently in 1998 or 1999. We do not mean to preclude plaintiffs from submitting the data in Indiana and other states to rigorous analysis. A few procedures were classified in the tables as "unknown," which may mask some effects – though the number of "unknown" procedures did not change much from the first to the second half of 1997. Our point is only that a simple inquiry reinforces the findings of fact made in the

Wisconsin case and implies that partial-birth-abortion statutes need not have the baleful effects that plaintiffs foresee.

III

Plaintiffs in both cases contend that, even if the statutes are precise enough to be enforced, they create an undue (and therefore unconstitutional) burden on abortion. The eighth circuit reached this conclusion in *Carhart* and its two companion cases, but only after first holding that the state laws effectively prohibit the D & E procedure. If we thought that the Illinois or Wisconsin laws forbade D & E, then *Planned Parenthood of Central Missouri v. Danforth* would require us to agree with the eighth circuit. For reasons we have already given, however, we believe that state courts are entitled to accept the view of both states' Attorneys General that their laws do not forbid, or even affect, the D & E procedure. The question we must address, then, is whether a statute limited to D & X unduly burdens abortion.

One reason why this might be so is that neither state's law contains an exception for situations in which the D & X procedure is necessary to protect the woman's health. A second argument is that any prohibition of any medical procedure unduly burdens a woman's right to abortion. The first line of argument finds some support in *Casey*, which held that any regulation of abortion must make an exception for procedures that protect "the woman's life *or health*", 505 U.S. at 846 (emphasis added), as well as our panel's decision in the Wisconsin case, 162 F.3d at 467-68, 470-71. But we do not think that the

plurality in *Casey* meant this as a universal rule, one applicable even when the procedure in question lacks demonstrable health benefits. The point that the plurality made was that a statute that lacks a "health exception" may unduly burden the woman's right to obtain an abortion before the fetus has reached viability; when state law offers many safe options to that end, the regulation of an additional option does not produce an undue burden.

Section 513/10 of the Illinois statute contains an exception for "a partial-birth abortion that is necessary to save the life of a mother because her life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering condition caused by or arising from the pregnancy itself, provided that no other medical procedure would suffice for that purpose." It does not contain a comparable exception for a partial-birth abortion that promotes the woman's health. Wisconsin's law has a similar structure. Both sets of plaintiffs contend that the lack of an exception for a woman's health dooms the statute. Coming from the Illinois plaintiffs, this is a weak argument indeed, for *none* of the plaintiff physicians or clinics in Illinois uses the D & X, and none asserts any desire to start. Whether the D & X procedure sometimes would protect a woman's health is therefore immaterial to *these* physicians and the women in their care. But several of the plaintiff physicians in the Wisconsin case do employ the D & X procedure on occasion, so we must consider the merits of the argument.

After a trial, the district court in the Wisconsin case concluded that the D & X procedure is *never* necessary from the perspective of the patient's health. 44 F.Supp.2d

at 979-82. This conclusion cannot be called clearly erroneous; as things transpired, it was not a seriously contested issue. None of the plaintiff physicians in that case testified to the contrary. The district court summed up:

> None of the physicians would state unequivocally that the D & X procedure is safer than the D & E procedure. Broekhuizen conceded that further study of the procedures is required. Smith admitted that he had never encountered a situation where D & X would have been the best procedure to use. Haskell, who invented the procedure, admitted that the D & X procedure is never medically necessary to save the life or preserve the health of a woman. Giles agreed.

Id. at 980. The judge added that, although the D & X procedure has been used for more than a decade, no published study compares the risks of D & X to those of D & E. *Id.* at 979. Some authors believe that the D & X procedure is more hazardous. See *Sprang & Neerhof, supra*, 280 J. Am. Medical Ass'n at 746 ("Intact D & X (partial-birth abortion) should not be performed because it is needlessly risky, inhumane, and ethically unacceptable."); Nancy G. Romer, *The Medical Facts of Partial Birth Abortions*, 3 Nexus 57 (1998).

Plaintiffs have not identified any data that undercut the district court's finding of fact. Their principal medical reference is the ACOG's 1997 statement and technical bulletin on the D & X procedure, which concluded that, although D & X is never the only medically appropriate option, choice still should be reserved to the physician. Although the statement asserts that D & X sometimes may be the best option, the ACOG did not identify any

concrete circumstance under which this would be so or provide support for the assertion. Several of the plaintiff physicians testified to like effect, again without specifics or data. No published medical study fills the gap. Cf. *Kumho Tire Co. v. Carmichael*, 119 S. Ct. 1167, 1177-79 (1999). Unelaborated avowals do not demonstrate that a finding of fact reached after a trial is clearly erroneous. When there is a conflict in the testimony – and that is the description most favorable to the plaintiffs – the finder of fact is entitled to choose. See *Anderson v. Bessemer City*, 470 U.S. 564 (1985). We proceed on the assumption, which appears to be shared by the American Medical Association, that the D & X is not the best or safest option in any articulable category of situations. The AMA's Policy H-5.982 concludes, among other things, that "there does not appear to be any identified situation in which intact D & X is the only appropriate procedure to induce abortion." The district court in Illinois did not make contrary findings, or indeed *any* finding; acting without a trial or even an evidentiary hearing, it could not properly have rendered "findings" about disputed issues. District courts in other circuits have disagreed with the conclusions the district judge reached in the Wisconsin case, but this does more to show that the issue is debatable among reasonable persons than to show that a particular view is in error.

The question in the end is not what one or another judge found on a given record; it is whether the state legislatures exceeded their constitutional powers. Factual premises underlying legislation normally are not subject to review by trial courts. *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 315 (1993); *Minnesota v. Clover Leaf*

Creamery Co., 449 U.S. 456, 463-65 (1981); *Vance v. Bradley*, 440 U.S. 93, 111 (1979); *National Paint & Coatings Ass'n v. Chicago*, 45 F.3d 1124, 1127 (7th Cir. 1995). The district court's findings, the statements of medical groups, and the inferences to be drawn from what has happened in states that have implemented partial-birth-abortion statutes, are informative rather than conclusive on the question whether the underpinnings of the legislation are tenable. See Henry P. Monaghan, *Constitutional Fact Review*, 85 Colum. L. Rev. 229 (1985). Although "undue burden" analysis does not map neatly to the standard classifications ("rational basis," "strict scrutiny," and the like), making it hard to know the extent to which courts must respect legislative decisions about contestable factual matters, it is significant that none of the Supreme Court's decisions in abortion cases suggests that the same law would be constitutional in one state, and unconstitutional in another, depending on a district judge's resolution of factual disputes. Thus we treat the findings in the Wisconsin case, like the view of the AMA, not as replacements for legislative conclusions, but as establishing that there is real, and not just hypothetical, support for a belief that the partial-birth-abortion laws do not pose hazards to maternal health. (This is the approach to evaluation of facts when the constitutional standard prescribes an intermediate level of analysis. See *Craig v. Boren*, 429 U.S. 190, 199-204 (1976).)

Only if every regulation related to abortions must contain a case-by-case "health exception" is there a problem with these laws. Yet *Casey* did not say that health effects must be evaluated case by case, rather than procedure by procedure. Abortions are not havens for junk

science – so that, for example, the state must let any chiropractor perform an abortion, if the chiropractor believes that manipulation of the spine is safest for the woman. Cases such as *Mazurek v. Armstrong*, 520 U.S. 968 (1997), which held that states may limit performance of abortions to physicians, permit laws that regulate by class of procedures (or of medical providers). Cf. *United States v. Rutherford*, 442 U.S. 544 (1979) (FDA may ban a generally ineffective drug, even though for a few people it may be the only cure). Doubtless some nurses are better than some physicians at performing abortions, so patients' health would be improved by allowing these nurses to perform abortions; yet the Court held that states may provide otherwise. Similarly, Illinois and Wisconsin concluded that the D & X procedure is not essential to protect the health of any woman, given the availability of other procedures. Compilation of additional information by the medical profession could call this conclusion into question. As things stand, however, interference with the operation of the state laws cannot be justified on the ground that the D & X procedure is necessary to protect women's health.

A requirement of a case-by-case "health exception" to every statute concerning abortion would amount to a rule that no state may regulate any abortion procedure. For a physician will use a particular procedure only if in the physician's judgment the procedure is superior in some way – faster, safer, more likely to work (and thus indirectly safer because an abortion can be achieved with one procedure rather than two, with cumulative risks), or perhaps less expensive (and thus again indirectly safer,

because the lower cost brings it within the reach of additional patients). Can plaintiffs, who object to the vagueness of the states' laws, really welcome a ruling under which every abortion creates the possibility of a prosecution in which the state invites a jury to disagree with the physician's assessment of the procedure's safety? A health exception, where jurors rather than physicians assessed health, would be an order of magnitude worse than the ambiguity plaintiffs perceive in the partial-birth-abortion laws. Perhaps plaintiffs believe that a "health exception" should make the physician's assessment of health consequences incontestable. That would avoid vagueness at the price of vitiating the laws. Some physicians are bound to think that a given procedure is safer or otherwise superior, even if the medical profession as a whole disagrees. A constitutionally based health exception for *every* procedure, coupled with a prohibition against review of physicians' beliefs about which procedures are safest, would amount to a rule that anything goes. And plaintiffs make this argument explicitly: they contend that any regulation of any medical procedure that pertains to abortion is an "undue burden" on women's rights.

To the observation that D & X is not an important procedure – indeed, that it is such a marginal procedure that few physicians anywhere in the nation (and none in Illinois) express any interest in performing it – plaintiffs rejoin that the question is not whether a law creates an undue burden for women as a group, but only whether it does so for those women it affects. The affected set here is women for whom a physician will think that D & X is the procedure most likely to succeed, or to entail the least

cost. For *these* women, plaintiffs contend, the burden is substantial and therefore "undue." Moreover, the argument continues, if the states are right – if D & X really is a procedure that the medical profession abjures – then the law must be political grandstanding. A restriction imposed for no better reason than to make a point has no benefits and therefore must be "undue," the argument concludes. On plaintiffs' approach, if the statutes actually accomplish something, then the burden is "undue" because the laws have effects; and if the laws accomplish nothing, then the burden is "undue" because any cost is excessive when the benefit is zero. Plaintiffs have the states both coming and going.

But this cannot be a sound understanding of *Casey*, or *Mazurek* would have come out the other way. By plaintiffs' lights, Montana's statute restricting the performance of abortions to licensed physicians would have had an "undue burden" on those women it affected – that is, the set of women for whom the extra cost of a physician's fees made obtaining an abortion impractical or burdensome. Yet the Court held that a physician-only rule is not an "undue burden," as the plurality in *Casey* used that phrase. What plaintiffs in our case really argue is not that limiting the D & X procedure to situations (if there are any) in which it is necessary to save the woman's life is an undue burden, when compared with other burdens (such as waiting periods, information requirements, parental approval or consultation requirements, and physician-only rules) that the Court has sustained; it is, rather, that *all* "burdens" are "undue" because women should have unfettered choice among medical procedures. But

then the phrase "undue burden" is simply redundant; the word "undue" does no work.

It is always difficult for a court of appeals to predict how Justices of the Supreme Court will apply a phrase with as much plasticity as "undue burden." But our best estimate is that "undue" rather than "burden" is the key word, and that "undue" means not only "substantial" (a small cost or inconvenience is not "undue") but also that the burden must be undue in relation to the woman's interests, rather than undue in relation to the court's assessment of society's interests. Plaintiffs' (implicit) argument that every regulation of a medical procedure is "undue" fails because many regulations create small burdens. The physician-only rule was one; a prohibition of D & X is another. Even for the class of women who seek late-second-trimester abortions, there is always one or more other safe methods of abortion in addition to D & X. Let us return to the natural experiment now under way. Plaintiffs do not contend that in any of the states where a partial-birth-abortion law is in effect, even one woman has been injured or denied an abortion because of the law.

As for the second branch of plaintiffs' argument – that because the partial-birth-abortion laws do not diminish the number of abortions, they must be condemned as moralizing rather than utilitarian laws – this calls on judges to recapitulate *Lochner*'s methodology. This line of argument amounts to the contention that *Casey* so restricts the states' power that states are limited to symbolic gestures; and then the states' very attempt to comply with *Casey* by refraining from substantially impeding women's access to abortion dooms their laws. We do not

read *Casey* as condemning states to this self-defeating legislative menu. So long as the law does not harm women's legitimate interests, the fact that the law's effects are small and justified by moral rather than utilitarian considerations does not spell unconstitutionality.

IV

One final issue requires attention. The district court in Illinois read 720 ILCS § 513/15 to establish a parental-consent requirement, which the court enjoined because it lacks a judicial-bypass procedure. 995 F.Supp. at 861, relying on a portion of *Casey*, 505 U.S. at 899-900, that reaffirmed *Hodgson v. Minnesota*, 497 U.S. 417 (1990). But what § 513/15 actually provides is different. It reads:

> The maternal grandparents of the fetus or infant, if the mother has not attained the age of 18 years at the time of the abortion, may in a civil action obtain appropriate relief unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion. The relief shall include money damages for all injuries, psychological and physical, occasioned by the violation of this Act and statutory damages equal to 3 times the cost of the partial-birth abortion.

Nothing here requires parental consent to a partial-birth abortion. Section 513/10 *forbids* most partial-birth abortions; no one can authorize that procedure in Illinois unless it is necessary to protect the woman's life, and then no parent's consent is necessary.

Section 513/15 provides civil damages for conduct that violates § 513/10, and it assigns the right to pursue

these damages to parents if the person who undergoes the procedure is a minor. A parent who gave consent to the procedure naturally can't recover damages, even though a criminal prosecution remains possible under § 513/10 if the mother's life was not in jeopardy. The possibility that a parent may consent to an unlawful procedure (and thus insulate the physician from civil damages), or consent to a life-saving procedure for which no consent was necessary in the first place, hardly implies that a judge also must be empowered to authorize a violation of § 513/10.

Wisconsin's civil-liability provision, Wis. Stat. § 895.038(2), is entirely derivative from its criminal-liability provision, and the district court held it valid because the criminal provision is valid. Plaintiffs in the Wisconsin case do not take issue with this approach: they argue only that § 895.038(2) is unconstitutional because § 940.16 is unconstitutional. We therefore do not discuss § 895.038(2) further.

Actually, we have said too much already about the civil-liability provisions. They are enforced in private litigation; the states' Attorneys General and local prosecutors have nothing to do with civil suits. Relief against the public officials therefore would be pointless even if the civil-liability provisions were problematic. See *Summit Medical Associates, P.C. v. Pryor*, 180 F.3d 1326 (11th Cir. 1999). There is no controversy between the parties to this case that can be resolved by a declaration concerning the civil-liability rules. But see *Okpalobi v. Foster*, 1999 U.S. App. LEXIS 22785 (5th Cir. Sept. 17, 1999) (purporting to enjoin a private-civil-damages provision in a suit to

which only state officers were defendants, without mentioning the eleventh circuit's conclusion in *Summit Medical*).

The judgments in both cases are vacated. The cases are remanded with instructions to enter the precautionary injunctions discussed in Part II.3 of this opinion, to dismiss the challenges to the civil-liability provisions for want of a case or controversy, and otherwise to enter judgment for the defendants.

VACATED AND REMANDED

POSNER, *Chief Judge*, with whom ROVNER, DIANE P. WOOD, and EVANS, *Circuit Judges*, join, dissenting. Compromise holds seductive allure for a court faced with a hot issue, and there is none hotter than the issue of abortion rights. The Illinois and Wisconsin statutes criminalizing "partial birth" abortion are challenged here both as being unconstitutionally vague and as unconstitutionally burdening the right of abortion. (These are independent grounds; if either is valid, the statutes are invalid.) The court rejects both challenges yet orders the district courts to enjoin enforcement of the statutes against any method of abortion other than the one the medical community refers to as "intact D & E" (that is, intact dilation and evacuation) or, more commonly, "D & X" (dilation and extraction). This is the form of "partial birth" abortion that gave rise to these statutes, although they are not limited to it.

The court's decision is not a real compromise. It leaves intact the core of the statutory prohibitions, which unlawfully burden the right of abortion by outlawing the D & X procedure. The court does toss a bone to the

plaintiffs, but at the cost of expanding federal judicial power over the states by a method that the Supreme Court has never countenanced and that violates Article III of the Constitution. It is a bone, incidentally, that the plaintiffs didn't ask for; neither side, in either case, requested this novel form of relief or commented on it in their briefs. We are taking a leap into the unknown without any input from the parties.

The "precautionary" injunctions that the court is directing the district courts to enter will forbid the enforcement of the statutes outside their core prohibition, thus placing the federal contempt power behind this court's interpretation of state statutes. The court does this while accepting the enforcers' assurances that they will not enforce the statutes outside the core, and concludes, therefore, "that the probability of improper prosecution is low." The states are nevertheless to be enjoined because the probability, though low, is greater than zero. The probability of improper prosecution under *every* criminal statute ever written is greater than zero; and so the court's decision, should it be followed outside the abortion context – and nothing in the decision suggests a principled limitation to that context – implies a radical expansion of the power of the federal courts to superintend the enforcement of state statutes. State officials will be subject to federal contempt sanctions for failing to abide by a federal court's interpretation of the statutes that these officials, not federal judges, are charged with administering.

The court adds that while the probability of improper enforcement *now* is low, given the assurances that the state law enforcement authorities have made in their

briefs in this court and at oral argument, the probability was high enough when these cases were brought to confront the plaintiffs with "a real risk" of being prosecuted for performing constitutionally privileged abortions. But if that is so, it means the statutes are unconstitutionally vague. If the law enforcers' present assurances are not enough to moot the case, how can they be enough to moot the central issue to which those assurances are addressed, the issue the court ducks of whether the statutes are in fact unconstitutionally vague? And if the present probability of improper enforcement is slight, as the court believes, what *equity* do the plaintiffs have to obtain an injunction?

The court is directing that state statutes be enjoined that it has not found either violate federal law or create a significant danger of such violation. This is unprecedented, and (on the court's view of the facts) violates Article III. If the court is right – I do not think it is, but it is the premise of the decision – that there is only a "nonzero" probability that either state statute will be enforced against any abortion procedure other than the D & X, the threatened injury is too slight to activate the curative powers of federal courts. A nonzero probability could be a probability of one in a thousand, or one in a million. A probabilistic injury can support standing, e.g., *Clinton v. City of New York*, 118 S. Ct. 2091, 2100-01 (1998); *Walters v. Edgar*, 163 F.3d 430, 434 (7th Cir. 1998); *North Shore Gas Co. v. EPA*, 930 F.2d 1239, 1242 (7th Cir. 1991), but the probability must be nontrivial, not merely nonzero. E.g., *Murphy v. Hunt*, 455 U.S. 478, 482-83 (1982) (per curiam); *City of Los Angeles v. Lyons*, 461 U.S. 95, 105-07 and n. 8 (1983); *Walters v. Edgar, supra*, 163 F.3d at 434-35. Otherwise the

federal courts will be flooded with cases, since few statutes are altogether free of vagueness; statutes that are too precise allow loopholes.

Lyons, the choke-hold case, makes the basic point. The probability that the plaintiff would again be arrested and subjected to a choke hold was held to be too slight to support standing. But it was no less than the implicit probability that this court today assigns to the threat of prosecution for performing abortions that the state law enforcement authorities concede are constitutionally privileged.

Although the injunctions that the court is ordering ostensibly are temporary, to remain in force only until the state courts have a chance to clarify the statutes, those courts are unlikely ever to get that chance, since the enforcement of the statutes beyond their core prohibition, which in the court's view needs no clarification, will be enjoined. Private civil suits are unaffected, but the provisions for civil enforcement of these statutes are limited and cases are unlikely. The Illinois statute authorizes civil suits only by the parents of a minor who has a "partial birth" abortion, and the Wisconsin statute by either the minor's parent or the fetus's father. Should a prosecutor indict a physician for performing a D & X, and the physician contend that it was really a D & E, the dispute will be resolved by the district court's interpreting its injunction in contempt proceedings. As a practical matter, the courts of Illinois and Wisconsin will never have an opportunity to explore the outer bounds of these statutes.

The court cites no case that authorizes such injunctions. It relies on cases such as *City of Chicago v. Morales*,

119 S. Ct. 1849, 1861 (1999), and *Village of Hoffman Estates v. The Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 494 n. 5 (1982), which hold that if a state statute has been interpreted by the state's highest court, the interpretation binds any federal court asked to decide the meaning of the statute. No case holds, however, that *until* the statute is construed by the state courts, a claim that it is unconstitutionally vague is premature. No case denies the authority of the federal courts to interpret state statutes, which is something we do all the time. No case holds that until a state statute is construed by the state courts its operation may be enjoined without a determination that the statute is unconstitutional. All the cases on which the majority relies involve federal courts either narrowing federal statutes that are fairly susceptible of being narrowed or accepting as authoritative a narrowing interpretation of a state statute by a state court. In no case cited by the majority did a federal court impose its own narrowing interpretation on a state statute by injunction, let alone a state statute the language of which defies a saving interpretation.

Although grounded in a concern with preserving the prerogative of state courts to interpret state statutes, today's decision curtails that prerogative by forbidding the states to enforce state statutes that the court has *not* found to be invalid. The decision is thus internally inconsistent (the court both rejects the charge that the statutes are unconstitutionally vague and, by enjoining their application outside their small clear core until they are clarified by the state courts, holds that they are too vague to provide fair warning – which means they *are* unconstitutionally vague, e.g., *Bouie v. City of Columbia*, 378 U.S.

347, 351 (1964)), as well as being an evasion of judicial duty, a violation of Article III, and an affront to federalism. The content of the injunctions that the court orders entered, moreover, is not specified; disputes over it will undoubtedly give rise to further litigation. And there will be a nice question of whether the plaintiffs can obtain attorneys' fees on the ground that they have won *something*, with the defendants arguing that it is *they* who have won the case because the court has both held the challenged statutes to be valid and accepted the defendants' assurances that the statutes will not be enforced beyond their valid scope.

On the merits, the most important issue raised by the appeals is that of undue burden. (I'll come back later to the substantive issue of vagueness, as distinct from the problems raised by the court's effort to evade the issue by means of the "precautionary" injunctions.) To understand this issue requires understanding the peculiar and questionable character of these statutes. They do not protect the lives of fetuses either directly or by seeking to persuade a woman to reconsider her decision to seek an abortion. For the statutes do not forbid the destruction of any class of fetuses, but merely criminalize a *method* of abortion – they thus have *less* to recommend them than the antiabortion statutes invalidated in *Roe v. Wade*, 410 U.S. 113 (1973). If any fetal lives are saved by these statutes, it will only be by scaring physicians away from performing *any* late-term abortions, an effect particularly likely in Wisconsin, whose statute imposes a punishment of life imprisonment for its violation. In tacit acknowledgment of that statute's especially questionable character, the majority opinion invites an Eighth Amendment

challenge should a lengthy prison sentence ever be imposed on a violator of the statute.

The statutes do not seek to protect the lives or health of pregnant women, or of anybody else, as by confining the performance of abortions to licensed physicians, as in *Mazurek v. Armstrong*, 520 U.S. 968 (1997) (per curiam), or to facilities equipped to deal with emergencies that may arise in the course of an abortion, particularly a late-term one. A legislature can ban quacks from practicing medicine without making an exception for those quacks (and no doubt there are some) who are abler than the worst physicians. Any general health regulation is likely to hurt a few people. But as banning "partial birth" abortions is not intended to improve the health of women (or anyone, for that matter), it cannot be defended as a health regulation.

The statutes make no exception for cases in which pregnancy results from rape or incest, or in which the fetus is profoundly deformed, nonviable, or unlikely to live more than a few hours after birth, or indeed, as I shall show, in which the woman's life would be endangered if she carried the fetus to term. The absence of any such exceptions is particularly surprising because late-term abortions are much less likely than the much more common first-trimester abortions to be motivated by considerations merely of convenience rather than of urgency. A woman who finds herself five months pregnant is unlikely to decide to have an abortion unless advised by her physician either that the fetus is profoundly deformed or that her own health requires that the pregnancy be terminated. Indeed, if the fetus has become viable, she *cannot* lawfully obtain an abortion unless her

life or health is in danger. Wis. Stat. § 940.15(3); 720 ILCS 510/5(1). These are constitutionally permissible protections of fetal life. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 879 (1992). It is incomprehensible to me why these states, if acting in good faith, were unwilling to write the same health exception into statutes that criminalize the abortion of nonviable as well as viable fetuses. The "partial birth" statutes do not distinguish between fetuses that are viable, in the sense of being sufficiently developed to be able to survive outside the mother's body, and those that are not. Some fetuses don't become viable until 27 weeks or even later, but the "partial birth" abortion, even defined so narrowly as to cover only the D & X procedure, is performed from 20 weeks on. A physician might be convicted of a felony violation of these statutes even though the Supreme Court has held that a state may not prevent the abortion of a nonviable fetus. *Id.* at 846, 877.

The statutes do not outlaw a particularly cruel or painful or horrifying mode of abortion. This can be shown with the aid of a simple example. Suppose that the fetus is hydrocephalic, so that its head is too large to pass through the cervix. If the physician performing the abortion crushes the fetus's skull in the uterus, killing the fetus while the fetus is still entirely within the uterus, he is not guilty of violating either of the statutes before us. But if before crushing the fetus's skull the physician turns the fetus around so that its feet are protruding into the vagina, he has committed a felony. In both cases, the fetus is killed by the crushing of its head in the uterus. (The crushing is necessary to enable the fetus to be removed through the birth canal without making the woman go

into labor.) From the standpoint of the fetus, and, I should think, of any rational person, it makes no difference whether, when the skull is crushed, the fetus is entirely within the uterus or its feet are outside the uterus. Yet the position of the feet is the *only* difference between committing a felony and performing an act that the states concede is constitutionally privileged.

The tortured efforts of the states' lawyers to provide guidance to physicians engaged in performing abortions – physicians who already are frequent subjects of picketing and other harassment and occasionally of physical assaults, see, e.g., *United States v. Soderna*, 82 F.3d 1370 (7th Cir. 1996), and who are now to be threatened with criminal prosecution and professional defrocking – make one thing clear: it is extremely difficult, indeed probably impossible, to distinguish a "partial birth" abortion from the methods of abortion that are conceded to be privileged. (This is the key to the statutes' vagueness, and so a point to which I'll return.) The principal reason for the difficulty is that, as my example of the hydrocephalic fetus suggests, there is no meaningful difference between the forbidden and the privileged practice. No reason of policy or morality that would allow the one would forbid the other. We should consider therefore why any state would pass such a law. An important part of the answer is found in Judge Manion's opinion in *Planned Parenthood of Wisconsin v. Doyle*, 162 F.3d 463 (7th Cir. 1998). The states want to dramatize the ugliness of abortion. "[A]ll methods [of abortion] are gruesome. But this is the one method that has been at least partially exposed to the light of day. . . . The exposure of this procedure has cast a bright light on the alternative procedures that are equally

gruesome. . . . No doubt when this statute is properly construed – [so] that it bans only the rarely-used D & X procedure – it does not appear to accomplish much in the way of saving babies. But these laws have certainly elevated the public's concern over the fate of the 'potential human lives' that are exposed to abortion." *Id.* at 477, 479 (dissenting opinion). From this standpoint, the more a "partial birth" abortion is like an abortion that is conceded to be constitutionally privileged, the better.

The wave of "partial birth" abortion statutes that broke over the nation after a description of the D & X procedure was publicized – see Martin Haskell, "Dilation and Extraction for Late Second Trimester Abortion" (1992), reprinted in 139 Cong. Rec. E1092, 1993 WL 135664 (Apr. 28, 1993), and in *The Partial-Birth Abortion Ban Act of 1995*, Hearing before the S. Comm. on the Judiciary, 104th Cong., 1st Sess. 5 (Nov. 17, 1995) – does not exhibit the legislative process at its best, whatever one thinks of abortion rights. Whipped up by activists who wanted to dramatize the ugliness of abortions and deter physicians from performing them, the public support for the laws was also based – as is implicit in Judge Manion's defense of the laws – on sheer ignorance of the medical realities of late-term abortion. The uninformed thought the D & X procedure *gratuitously* cruel, akin to infanticide; they didn't realize that the only difference between it and the methods of late-term abortion that are conceded all round to be constitutionally privileged is which way the fetus's feet are pointing. Opposition to the bills that became these laws was at first muted not only by ignorance of the character of a late-term abortion but also by the fact that few women are likely to be affected

by the laws. Circumstances conspired, as it were, to produce a set of laws that can fairly be described as irrational.

This is a harsh verdict, but doubt about its soundness is laid to rest by the absence of any exception for situations in which a "partial birth" abortion is necessary to protect the pregnant woman's health. The right of abortion is unduly burdened by any law that endangers the woman's health. Even a law that limits only the right to abort viable fetuses – a limitation not found in the statutes challenged in this case – must, to pass constitutional muster, make an exception "for pregnancies which endanger the woman's life *or health.*" *Planned Parenthood of Southeastern Pennsylvania v. Casey, supra*, 505 U.S. at 846 (emphasis added). Immediately the question arises why the Wisconsin and Illinois legislatures didn't try to come within reach of the cases that permit states to limit the right of abortion by making an exception for pregnancies that endanger the woman's health, the same exception they have written into their other abortion statutes. When pressed at argument, the lawyers for the two states could answer only that the exception is unnecessary. The lawyers were confident that such an abortion is *never* required to preserve a woman's health. They may be right, though I think not (more on this below). But if so, they are right only for today. Tomorrow, studies may show that, yes, there indeed are cases where a "partial birth" abortion is necessary to protect the mother's health, as many physicians believe. Tomorrow, then, these two statutes may be unconstitutional even by the lights of the majority opinion. Why would a state risk the early obsolescence of its statute by making it wholly dependent

on ever-changing medical opinion, when to avoid this risk it need only have excepted those "partial birth" abortions, if any, that are necessary to protect the woman's health? If there are few such cases, the exception will rarely be invoked; if none, never.

The answer is that opponents of abortion do not think there should be an exception for abortions that endanger a woman's health. Life, yes, but not health. These statutes, remember, are not concerned with saving fetuses, with protecting fetuses from a particularly cruel death, with protecting the health of women, with protecting viable fetuses, or with increasing the Wisconsin population (as intimated, surely not seriously, by Wisconsin's counsel). They are concerned with making a statement in an ongoing war for public opinion, though an incidental effect may be to discourage some late-term abortions. The statement is that fetal life is more valuable than women's health.

I do not deny the right of legislatures to enact statutes that are mainly or for that matter entirely designed as a statement of the legislators' values. *Milner v. Apfel*, 148 F.3d 812, 814 (7th Cir. 1998). Nothing in the Constitution forbids legislation so designed. Many statutes are passed or, more commonly, retained merely for their symbolic or aspirational effect. But if a statute burdens constitutional rights and all that can be said on its behalf is that it is the vehicle that legislators have chosen for expressing their hostility to those rights, the burden is undue. The statutes before us endanger pregnant women – and not only pregnant women who *want* to have an abortion. There is no exception for women whose physicians tell them you *must* have an abortion or die. It is true that if a

"partial birth" abortion is necessary to save the woman's life, the statutes permit this. But if her life could be saved by another type of abortion, even one that threatened her health – that threatened to sterilize her or to paralyze her – then the physician would be committing a felony if he performed a "partial birth" abortion. I cannot believe that my colleagues would think the physician could be punished in such a case, and I wonder therefore why the "precautionary" injunctions do not extend to it. The statutes allow a "partial birth" abortion to be performed if "no other medical procedure would suffice for that purpose" (that is, saving the mother's life). Wis. Stat. § 940.16(3); 720 ILCS 513/10. Could not "would suffice" be interpreted to mean "would be as good as from the standpoint of the woman's health"? Such an interpretation, no more audacious than the interpretive leaps that underlie the order to enter "precautionary" injunctions, would seem compelled by the court's own reasoning, but goes unremarked. If the interpretation is rejected, it would imply that a D & X would be forbidden even if the only alternative were a hysterectomy. That can't be right.

The court points out that it is unclear how many women are endangered by these statutes. The forbidden procedure is performed only (or almost only) in late-term abortions, which fortunately are rare; and only in some unknown fraction of them is a "partial birth" abortion the medically preferable procedure. But government cannot without a reason forbid a person to obtain medical treatment and if challenged defend by pointing out that most people don't need that treatment. In the context of abortion this principle is implicit in the statement in *Planned Parenthood of Southeastern Pennsylvania v. Casey, supra*, 505

U.S. at 878, that "purpose *or* effect" (emphasis added) – and thus purpose alone – "to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability" condemns an antiabortion statute. E.g., *Okpalobi v. Foster*, No. 98-30228, 1999 WL 728396, at *16-20 (5th Cir. Sept.17, 1999); *Jane L. v. Bangerter*, 102 F.3d 1112, 1116-18 (10th Cir. 1996). That is no constitutional novelty; statutes that burden other constitutional rights besides the right of abortion have been invalidated on the basis of improper purpose. E.g., *Edwards v. Aguillard*, 482 U.S. 578 (1987). The *Casey* opinion speaks of placing a substantial obstacle in the path of "a woman," not "many women." Imagine a married woman, pregnant, told by her physician that her life depends on her obtaining an abortion. He tells her it would be better from the standpoint of minimizing the risk to her of medical complications from the abortion for her to have a D & X. But, he adds, unfortunately the law prohibits the procedure. It does so not because the procedure kills the fetus, not because it risks worse complications for the woman than alternative procedures would do, not because it is a crueler or more painful or more disgusting method of terminating a pregnancy, but because the state wishes to make a statement of opposition to constitutional doctrine. A legislature may be taken to intend any consequences of its handiwork that are at once natural, highly probable, and wholly foreseeable (and foreseen). Here the intent is to block a woman from seeking an abortion when her doctor advises her that the best procedure for her is criminal.

The statutes' improper purpose is further shown by the terminology they employ. The Wisconsin statute

defines a fetus from the moment of conception to the moment of birth as a "child" (thus absurdly implying that when we are born we are no longer children). The Illinois statute defines the fetus, also from the moment of conception, as an "infant." If these definitions are sound, *all* abortion is infanticide, which is not the Supreme Court's view. A state cannot be permitted to abrogate federal constitutional rights by definition. Line drawing is inescapable but the line between feticide and infanticide is birth. Once the baby emerges from the mother's body, no possible concern for the mother's life or health justifies killing the baby. But as long as the baby remains within the mother's body, it poses a potential threat to her life or health and this threat presents a compelling case (or so at least the Supreme Court believes) for a right of abortion. The Wisconsin statute, whose provision for life imprisonment already marks it as the crazier one, also allows either of the fetus's grandparents to sue in respect of a "partial birth" abortion. One can imagine a father who cares more for having a grandchild than he cares for the health of his daughter threatening to sue in order to block a "partial birth" abortion, while the mother (who may be divorced from the father), valuing the situation differently, sits on the sideline, helpless to protect her daughter.

In concluding that the challenged statutes do not pose any threat to women's health, the court relies heavily on tendentious factfindings by the district judge in the Wisconsin case. He fastened on the fact that a Dr. Harlan Giles believes that the D & X procedure is rarely, maybe never, necessary for the protection of the pregnant woman's health. The judge brushed aside the contrary

testimony of reputable physicians – more reputable, perhaps, as we're about to see, than Dr. Giles. Giles's testimony is essentially the only basis of the judge's finding, and the judge's finding is the principal basis on which this court, disregarding the contrary findings in the Illinois case, dismisses concerns about the absence of a health exception. Yet apart from everything else, Judge Shabaz's opinion is internally contradictory. He acknowledged that the D & X procedure, being quicker and easier to perform on fetuses that are more than 18 weeks old, has advantages for the woman's health in reducing the amount of bleeding, the risk of uterine perforations, and the amount of time that she has to be under anesthesia. *Planned Parenthood v. Doyle*, 44 F. Supp. 2d 975, 979 (W.D. Wis. 1999). Yet without retracting these findings, he concluded that the procedure is never necessary to protect the woman's health.

I daresay reputable physicians can be found who believe that surgery is never necessary in a case of prostate cancer, or that all vitamins are worthless, or that no efforts should be made to resuscitate a person over 80 years old who experiences cardiac arrest, since he is quite likely to be "revived" to a vegetative state. Dr. Giles may not even be wholly reputable. Another district judge rejected his testimony in opposition to the D & X procedure because, among other reasons, Giles was "more focused on the political aspects of the abortion debate than on the medical questions essential to resolution of the issues presented in this action. And, Dr. Giles was evasive when responding to questions directed at crucial issues in the case. Hence the testimony of Dr. Giles was neither credible, reliable nor helpful." *Richmond Medical*

Center for Women v. Gilmore, No. Civ. A. 3:98 cv 309, 1999 WL 507453, at *7 (E.D. Va. July 16, 1999) (footnote omitted). Another district judge criticized Giles – who appears to be a member of that much-criticized fraternity, the professional expert witness – for pronouncing on an abortion statute with which he was unfamiliar. *Evans v. Kelley*, 977 F. Supp. 1283, 1309-10 (E.D. Mich. 1997). Another rejected his testimony that the D & X is "a resurrection of an obstetric method discarded in the 1960s, which was used to deliver dead fetuses, and known as craniotomy," and concluded that Giles's criticisms of the D & X procedure were "not persuasive." *Women's Medical Professional Corp. v. Voinovich*, 911 F. Supp. 1051, 1070 (S.D. Ohio 1995), aff'd, 130 F.3d 187 (6th Cir. 1997).

Judge Shabaz, his only support the dubious Dr. Giles, stands alone among district judges who have made fact-findings concerning the potential benefits of the D & X procedure for women's health. See *Rhode Island Medical Society v. Whitehouse*, No. C.A. 97-416L, 1999 WL 683846, at *22 (D.R.I. Aug. 30, 1999) (contrary testimony is "unbelievable"); *Richmond Medical Center for Women v. Gilmore*, *supra*, at *44-45; *Carhart v. Stenberg*, 11 F.Supp.2d 1099, 1124-26 (D. Neb. 1998), aff'd, 1999 WL 753919 (8th Cir. Sept. 24, 1999); *A Choice For Women v. Butterworth*, 54 F.Supp.2d 1148, 1153, 1156-57 (S.D. Fla. 1998); *Hope Clinic v. Ryan*, 995 F.Supp. 847, 852 (N.D. Ill. 1998) (the decision reversed today without regard for the district judge's findings); *Evans v. Kelley*, *supra*, 977 F. Supp. at 1296; *Women's Medical Professional Corp. v. Voinovich*, *supra*, 911 F. Supp. at 1070; see also *Causeway Medical Suite v. Foster*, 43 F. Supp.2d 604, 608, 613-14 (E.D. La. 1999); *Planned Parenthood of Central New Jersey v. Verniero*, 41 F. Supp. 2d

478, 484-85 (D.N.J. 1998). If this court is to give weight to district judges' assessment of the credibility of the physicians who have testified pro or con the D & X procedure, it ought at least to acknowledge that Judge Shabaz is in a minority of one.

In refusing to give any weight to the findings of fact made by Judge Kocoras in the *Hope* case, the court seems to have forgotten that we are reviewing his judgment too. It is not some unrelated case that we are free to ignore on the ground that it is based on a different record from any before us. His findings, made in a proceeding that resulted in the issuance of a permanent injunction against the Illinois statute, are entitled to as much weight as Judge Shabaz's, *Knapp v. Northwestern University*, 101 F.3d 473, 478 (7th Cir. 1996); *Durasys, Inc. v. Leyba*, 992 F.2d 1465, 1471 (7th Cir. 1993) – more, really, because they are not infected by the internal contradiction that weakens Judge Shabaz's findings. If those findings justify our upholding the Wisconsin statute, Judge Kocoras's should lead us to invalidate the Illinois statute.

The court denies that Judge Kocoras *made* findings. I don't understand this. It is true that he based his findings on affidavits rather than on live testimony, but the state did not challenge the facts contained in the affidavits, including the facts about the medical advantages of the D & X procedure. Findings do not lose weight by being based on uncontested facts; admissions are not weaker evidence than facts found after vigorous contest. And if it were true that there were no findings in the Illinois case, this would call for a remand; it would not entitle us to plug Judge Shabaz's findings into a separate litigation

with no common parties. (What kind of transplant is *that*?)

Consistent deference to district court factfindings in this pair of cases would lead to an inconsistent result – the upholding of one statute and the condemnation of its sister. This demonstrates that the constitutional right of abortion cannot be made to depend on whether a particular district judge finds a particular physician who disagrees with the consensus of medical opinion to be more credible than the spokesmen for the consensus. The consensus here is found in the statement by the American College of Obstetricians and Gynecologists (ACOG) that the D & X procedure "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision." As Judge Shabaz himself acknowledged, the procedure reduces the risk of lacerating the uterus and the cervix with the sharp instruments used in the standard D & E. Such lacerations cause trauma and loss of blood. The D & X also reduces the risk that fetal tissue will remain in the woman's body, where it can cause infection. It reduces the length of time that the woman is under anesthesia. And it facilitates testing for genetic abnormalities, which is particularly important to the woman's decision whether to become pregnant again. (So much for the suggestion of Wisconsin's lawyer that banning the D & X will lead to more births.) Not all physicians agree with these points; and ACOG hedged its opinion by noting that a select panel of physicians had been unable to

identify specific circumstances in which there is no satisfactory alternative to a D & X. But the team of Dr. Giles and Judge Shabaz are, with all due respect, not competent to resolve this medical controversy.

How often the circumstances sketched in the previous paragraph that led ACOG to recommend retention of the D & X as a treatment option in late-term abortions will be present is not critical. It is slight consolation to be told that while the state has forbidden the optimal treatment of your medical problem, that problem happily is rare. Although we haven't been told of cases in states that have enacted laws forbidding "partial birth" abortion that were not promptly enjoined in which the consequence has been to endanger women, for all we know women in those states go out of state if they are candidates for a D & X. Cf. *Jane L. v. Bangerter, supra*, 102 F.3d at 1117. That would be the prudent course. My colleagues in the majority perform their own statistical analysis, outside the record, in an effort to refute this possibility. I have no objection to a court's relying on extra-record evidence to determine the health effects of "partial birth" abortion. Those effects should indeed be treated as a legislative fact rather than an adjudicative fact, in order to avoid inconsistent results arising from the reactions of different district judges, sheltered by the deferential "clear error" standard of appellate review of factfindings, to different records – the inconsistency illustrated by the different findings of Judges Shabaz and Kocoras in the two cases before us. Even so, we should hesitate to play statistician. It is incongruous for this court to brush aside

the findings of district judges in other cases while bolstering Judge Shabaz's inadequate findings with extra-record evidence of its own.

The court tries to shore up Judge Shabaz's findings with two medical papers. One of these, however, Nancy G. Romer, "The Medical Facts of Partial-Birth Abortion," 3 *Nexus: A Journal of Opinion* 57 (1998), is not a medical paper at all. Although the author is an M.D., she is also a pro-life activist, and the burden of her paper is that viable fetuses should be saved rather than aborted. This is a respectable ethical stance but it has nothing to do with the medical pros and cons of a D & X. The other paper, M. LeRoy Sprang & Mark G. Neerhoff, "Rationale for Banning Abortions Late in Pregnancy," 280 *JAMA (Journal of the American Medical Association)* 744 (1998), appears in a section of *JAMA* captioned "controversies," and though it does point out possible dangers to the woman from the procedure, the authors are heavy on the ethical issues involved in abortion. Like Dr. Romer, they come out in opposition to late-term abortion by *any* method, and opine very unscientifically that "partial birth" abortion is "closer to infanticide than it is to abortion." *Id.* at 746. Another medical article in the same issue of *JAMA* concludes that the D & X procedure should, as ACOG concluded, be an option for the physician. See David A. Grimes, "The Continuing Need for Late Abortions," 280 *JAMA (Journal of the American Medical Association)* 747 (1998). The court does not cite that article.

No hypothesis has been proposed by either of the states, or by the *amici curiae* who have submitted briefs in support of the Wisconsin statute, as to why physicians would perform, or the American College of Obstetricians

and Gynecologists support, a method of abortion that benefits no patient. There has been no suggestion of any pecuniary incentive that might cause them to engage in a controversial procedure of this kind.

Apart from performing its own statistical analysis and bringing to bear so-called medical papers, the court evinces its queasiness about resting entirely on Judge Shabaz's findings by saying that "the question in the end is not what one or another judge found on a given record" (the question the court had spent so much time discussing). "It is enough that there is real, and not just hypothetical, support for a belief that the partial-birth-abortion laws do not pose hazards for maternal health." This sounds suspiciously like the test for whether a statute has a rational basis, see, e.g., *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 315 (1993), and so may explain the court's one-sided treatment of the facts (the failure to cite Dr. Grimes's paper, for example). Rational basis is not the issue here. The issue is whether the Wisconsin and Illinois "partial birth" statutes impose an undue burden, and specifically whether they are a threat to maternal health. That is rightly an issue of legislative fact, meaning that its resolution is not to be cabined by facts determined in an adjudicative hearing; still it must be resolved in accordance with the weight of the evidence, including such extra-record evidence as the consensus of the relevant expert community, in this case the medical community. It is not enough to note that there is some evidence in support of one side of the issue, when there is more evidence on the other side. In the case the court cites as illustrating the appropriate scope of review, *Craig v. Boren*, 429 U.S. 190, 199-204 (1976), the Supreme Court

critically reviewed statistical evidence underlying the claimed constitutionality of the challenged statute – and found it wanting. When one critically reviews the testimony of Dr. Giles, and the court's own statistical analysis, and the so-called medical papers, and weighs them against the evidence that establishes the medical consensus, it becomes apparent that the court does not take the standard of *Craig* seriously.

Let me suggest an analogy. Suppose that a legislature in the South in the 1950s had listened to several "reputable" cognitive psychologists testify that blacks as a group are slow learners, and hence that they should be educated in separate schools. No one would argue that this legislative finding, because supported by *some* evidence from the relevant expert community, would have to be accepted in deciding the constitutionality of segregated education. The court, if it thought the issue relevant, would have to decide whether the finding was correct before relying on it. Similarly, the Wisconsin and Illinois legislatures are not entitled to ban an abortion procedure that the medical community believes may be preferable from a medical standpoint for some women, simply because a marginally reputable expert (Dr. Giles) thinks that the set of women for whom the procedure is preferable is actually zero. That might bear on the legislatures' good faith (though there is contrary evidence on that too, as I have pointed out), but it would not decide the issue of the statutes' effects on the right of abortion.

Enough said: banning the D & X, the core prohibition in these statutes, imposes an undue burden on women who seek to have an abortion, and is therefore unconstitutional. Let me turn now to the alternative ground of

vagueness. Both statutes forbid the partial vaginal delivery of a living fetus, and this describes many instances of the D & E method of abortion – which the court acknowledges cannot constitutionally be banned, see also *Carhart v. Stenberg*, Nos. 98-3245NE, 1999 WL 753919 (8th Cir. Sept. 24, 1999); *Little Rock Family Planning Services, P.A. v. Jegley*, No. 99-1004EA, 1999 WL 753928 (8th Cir. Sept. 24, 1999); *Planned Parenthood of Greater Iowa, Inc. v. Miller*, No. 99-1372SI, 1999 WL 753770 (8th Cir. Sept. 24, 1999) – as well as it does the D & X. Judge Shabaz himself acknowledged that "often" in the course of a D & E there is a fetal heartbeat after portions of the fetus have been delivered into the vagina, 44 F. Supp. 2d at 977, making the D & E definitionally a "partial birth" abortion under both statutes. The court's response, as I noted at the outset of this dissent, is not to hold that the statutes are unconstitutionally vague, but instead to hold that they can't be enforced against any procedure except the D & X until the Wisconsin and Illinois state courts have had a chance (the chance that is unlikely ever to come) to "interpret" their statutes to permit the standard D & E method even when it results, as it frequently does, in the partial vaginal delivery of a living fetus.

Putting to one side my objections to the court's procedure, which I discussed at the outset of this dissent, I note that the court seems to have bought into the legal-realist view that a statute means whatever the courts say it means, despite the Supreme Court's admonition that a court "may impose a limiting construction on a statute only if it is 'readily susceptible' to such a construction." *Reno v. American Civil Liberties Union*, 521 U.S. 844, 884 (1997), and cases cited there. If the realists are right, and

the contrary intimations of cases such as *Reno v. American Civil Liberties Union* can be brushed aside, I wish the court would, as I suggested earlier, hold that these statutes can be further narrowed by "precautionary" injunction to make an exception for cases in which the D & X procedure is necessary to protect the woman's health. The interpolation of such an exception would be no greater act of judicial *hubris* than narrowing the statute to the D & X when the draftsmen of the statutes decided *not* to use that term, preferring a vaguer term intended to be broader.

The constitutional law of vagueness is obviously in turmoil and so I shall suggest a lowest-common-denominator approach with which I think few judges will disagree, however much they may disagree about its application to particular cases. If a criminal statute is so worded that it is highly likely to condemn a constitutionally privileged act, and if the constitutionally privileged actor could not as a practical matter avoid being punished for engaging in such an act by raising a defense in a criminal proceeding, then the statute is enjoinable, in advance of any prosecutions, as unconstitutionally vague. For the very existence of such a statute "deter[s] constitutionally protected activity." *Coe v. County of Cook*, 162 F.3d 491, 496 (7th Cir. 1998), and cases cited there. When vague statutes prescribe heavy penalties for their violation, rational people avoid any conduct that might be thought to fall within the statute's scope, even if in an error-free litigation the conduct would be sure to be found constitutionally protected. See, e.g., *Village of Hoffman Estates v. The Flipside, Hoffman Estates, Inc.*, *supra*, 455

U.S. at 494 n. 6; *Colautti v. Franklin*, 439 U.S. 379 (1979); *Charles v. Daley*, 749 F.2d 452, 460 (7th Cir. 1984).

When the demanding conditions that I have outlined are satisfied, the statute is invalid, and the legislature has to go back to the drawing board. The court cannot rewrite the statute, or tell the state courts how to rewrite it, and, in advance of any further interpretation, uphold the rewritten statute. That procedure, the procedure followed by the court today, in effect nullifies the doctrine of unconstitutional vagueness.

These statutes are either absurdly (and unlawfully) overbroad or remarkably vague, and the court's direction to issue "precautionary" injunctions is a tacit acknowledgement of its inability to give the statutes a plausible narrowing interpretation; the confused concessions of the states' lawyers at the oral argument were no help in the endeavor. Although the statutes are addressed to physicians – it is their conduct alone that is regulated – the language employed is not medical language. Instead of denoting the victim of illegal abortion as a live fetus, a fetus with a heartbeat, or a viable fetus (a fetus, remember, that can survive outside the mother's body), the Illinois statutes refers to "a living human fetus or infant," terms that the statute explains are "used interchangeably to refer to the biological offspring of human parents," 720 ILCS 513/5, while the Wisconsin statute refers to "a living child" or "partially delivered child," with "child" defined, as I noted earlier, as "a human being from the time of fertilization until it is completely delivered from a pregnant woman." Wis. Stat. §§ 940.16(1)(a), (b). The use of such language makes the statutes incurably ambiguous. Neither "biological offspring" nor "living" is

defined. At argument the Solicitor General of Illinois was emphatic that "biological offspring" is a synonym for "intact fetus," that is, a fetus (however deformed) before the physician performing the abortion begins to work on it. But he retreated from this position when faced with the hypothetical case of a physician who, intending to perform a D & X, removes a limb or other part of the fetus before beginning the procedure. His retraction was consistent with his statement that the Illinois legislature had tried to make the statute "as broad as possible." More extensive dismemberment than merely removing a limb or two, Wisconsin's lawyer assured us, would inevitably kill the fetus before any part of it emerged from the uterus. She offered no basis for this hopeful bit of medical advice, and it is wrong. *Carhart v. Stenberg, supra*, at *4; *Richmond Medical Center for Women v. Gilmore, supra*, at *10. By "killing" the fetus, she evidently meant doing something to cause its heart to stop beating, although a fetus is living before it develops a heart. Obviously a one-day old embryo, like the cells that compose a living human body, is alive, not "dead."

In a standard D & E, part or all of the fetus often will still have a heartbeat, and so be "living," in the sense of the word apparently intended by the legislatures, when it emerges from the uterus. Therefore it is "partially vaginally delivered," just as in a D & X. "During the D & E procedure, the fetus may be removed from the uterus and brought through the cervix and vagina either intact or disarticulated. . . . [I]t may happen that part of the intact fetus will be in the vagina and part in the uterus or a disarticulated part of the fetus will be in the vagina while the remainder of the fetus is in the uterus. In either

of these situations, that part of the fetus which remains in the uterus may still have a heartbeat." *Planned Parenthood of Central New Jersey v. Verniero, supra*, 41 F. Supp. 2d at 484. If the physician then kills the fetus, he would, one would think, be guilty of having violated these statutes, which punish the killing of a fetus that has been partially vaginally delivered.

Against this interpretation, the Illinois Solicitor General, discarding settled principles of criminal law for the sake of a short-term victory, declared that the statute would not be violated unless the physician had *planned* before beginning the abortion to wait until a part of the fetus had emerged from the uterus and kill the fetus then; the mere fact that the physician knew it was likely that a part of the fetus would be outside the uterus at the moment of death would not show the requisite intent. By this logic – which the state's Solicitor General actually embraced at argument – if you fire a machine gun into a lighted college dormitory at night, reckoning that you have only a 10 percent chance of actually killing anyone, and you do kill one or more of the residents, you are not guilty of murder, provided you didn't want to kill anyone but just wanted to see whether your machine gun was in working order. The law is otherwise. First-degree murder in Illinois requires only that "in performing the acts which cause the death" the defendant "knows that such acts create a strong probability of death or great bodily harm." 720 ILCS 5/9-1; *People v. Daniels*, 702 N.E.2d 324, 330-31 (Ill. App. 1998); *People v. Mitchell*, 601 N.E.2d 916, 919 (Ill. App. 1992); *Hennon v. Cooper*, 109 F.3d 330, 333-334 (7th Cir. 1997). A physician who performs a standard D & E knowing, as he must, before he begins, that

part of the fetus is quite likely to be outside the uterus when he kills the fetus, and then kills it after a part has emerged from the uterus, is guilty of the crime of partially vaginally delivering a living fetus and then killing it.

The Illinois statute itself, moreover, requires only that the partial-birth abortion have been performed "knowingly." 720 ILCS 513/10. Under the law of Illinois, a defendant is deemed to know "the result of his conduct, described by the statute defining the offense, when he is consciously aware that such result is practically certain to be caused by his conduct." 720 ILCS 5/4-5(b).

Wisconsin authorizes life imprisonment for performing a "partial birth" abortion. That is the state's heaviest penalty, the penalty for murder. Wisconsin deems its statute – as both the penalty and the use of the term "child" to denote the fetus reflect – a law against infanticide. (So does Illinois, by using the term "infant," but it is not serious, because the maximum punishment for killing the "infant" is only three years.) No one would suppose, in the example of shooting into a dormitory, that if only a one-day-old baby were killed the killer would be innocent of murder. If Wisconsin is serious in regarding a fetus that has begun to emerge from the uterus as "a living child" who should be protected to the full extent of the law against murder, it cannot rationally interpret the statute to permit the physician to escape punishment by the plea that when he began the abortion he thought there was only a 50 percent chance that he would be killing "a living child." It would be like arguing that if a nurse hit a newborn over the head with a baseball bat, with all her might, not to kill it but merely to make it stop

crying, and the newborn died, the nurse could defend against a charge of first-degree murder by proving that while she thought it quite possible that the newborn would die, she didn't want it to die and thought it had a 50 percent chance of surviving.

Any doubts on this score are stilled by Wisconsin's statutory definition of intentional. The statute punishes "intentionally" performing a partial birth abortion, Wis. Stat. § 940.16(2), and the term means either acting purposely to accomplish the forbidden end *or* being "aware that [one's] conduct is practically certain to cause that result." Wis. Stat. § 939.23(3). As glossed by the case law, the alternative definition is satisfied by conduct carrying a known high risk of the forbidden result even if that result is not desired. See *State v. Gould*, 202 N.W.2d 903, 906 (Wis. 1973); *State v. McCarter*, 153 N.W.2d 527, 529 (Wis. 1967); *State v. Webster*, 538 N.W.2d 810 (Wis. App. 1995). In *Webster*, where the defendant was convicted of attempted first-degree murder, it was deemed irrelevant that the jury might have accepted his testimony "that he precisely aimed the shotgun at Hood's armpit, and that the gun was loaded only with shotshells filled with bird shot." 538 N.W.2d at 815.

So the state-of-mind requirements of the two statutes turn out to be the same. They are, moreover, the standard state of mind requirements for liability for serious crimes. A criminal defendant acts intentionally, and, even more clearly, knowingly, "when he knows that that result [here, a 'partial birth' abortion] is practically certain to follow from his conduct, whatever his desire may be as to that result." 1 Wayne R. LaFave & Austin W. Scott, Jr., *Substantive Criminal Law* § 3.5, p. 304 (1986); see, e.g., *United*

States v. United States Gypsum Co., 438 U.S. 422, 444-46 (1978); *Smith v. Farley*, 59 F.3d 659, 663 (7th Cir. 1995); *United States v. McAnally*, 666 F.2d 1116, 1119 (7th Cir. 1981).

I have discussed the state of mind requirements of these statutes at such length in order to make clear how little mileage the court can get from the cases that it cites, such as *Screws v. United States*, 325 U.S. 91 (1945), that save vague statutes by narrow interpretations. Put aside the fact that these were federal statutes given narrowing interpretations by federal courts, rather than state statutes given narrowing interpretations by federal courts, and that the Supreme Court in *Bellotti v. Baird*, 428 U.S. 132, 146-47 (1976), a decision that is still good law on this point, held that the proper way to obtain a narrowing interpretation of a vague state abortion statute is to abstain in favor of the state courts. The point I wish to stress is that the device used in *Screws* and many similar cases to save the statute, that of interpolating a *scienter* requirement, is unavailable here. And this for two reasons. The first is that the Wisconsin and Illinois statutes make clear what the state of mind requirement for guilt under each statute is, leaving no room for interpolating such a requirement in the guise of interpretation; and the second is that the problem with knowing what these statutes require of a physician is not ignorance of legal obligation, but ignorance of the factual premises of liability. The statute challenged in *Screws* made it a crime to deprive a person of a constitutional right. The Court held that the statute could be saved by requiring that the defendant be shown to have *known* that he was violating a constitutional right. It was a realistic requirement because the set

of constitutional rights at any moment is more or less known and it is a straightforward (though not always easily answerable) factual question whether the defendant knew that his conduct infringed something in that set. No one knows what procedures constitute "partial birth" abortion, and specifically whether many, perhaps most, D & E's do, given that the fetus often has a heartbeat after part of the fetus has emerged from the uterus. Screws, when he beat his victim to death, knew that he was committing the assault; the question was whether he knew that the assault (because he was a sheriff and his victim an arrestee) violated the Constitution. Physicians performing late-term abortions in Illinois and Wisconsin do not know whether they are performing "partial birth" abortions and thus committing crimes.

The incurable vagueness of these statutes might seem to be of little moment if a physician prosecuted for infanticide or feticide had a sure defense should the prosecution stray beyond the narrow path to which the court today attempts to confine the statute. He could not avoid prosecution but at least he would know he would be acquitted, and if he were lucky he would be let out on bail pending trial and maybe Planned Parenthood would pay his legal fees. But let us be realistic, and not only about the possibility of legal error. The physician is not the real target of the statute; the pregnant woman is. It is not the physician's pregnancy that is to be terminated. He has no incentive to undergo the agony of a criminal prosecution merely in order to perform an abortion in a particular way. Better for him either to abandon late-term abortions altogether, or to be sure to give the fetus a lethal injection in utero, and wait for it to take effect,

before performing the abortion. The *in terrorem* effect of these statutes, especially the Wisconsin statute with its maximum penalty of life imprisonment, is likely to induce physicians in these states to steer well clear of the forbidden zone. What physician would be fool enough, or hero enough, to risk a criminal prosecution in order to explore the precise meaning and outer bounds of the precautionary injunctions that this court has ordered the district courts in these two cases to enter, even if the risk is small?

And now we can see more clearly one of the fallacies in the "precautionary" injunction gimmick. It is the existence of these statutes, because of their extraordinary breadth and the limited incentive of a physician to test their scope, not the risk of prosecution, which may indeed be slight, that burdens those abortion rights that are conceded to be constitutionally protected. A peculiarity of abortion rights is that they require the assistance of a third party, the physician, who has a lesser interest in them than his patient. Because his interest is less, he is more easily deterred, and this should increase our concern with the deterrent effects of these vague statutes.

It remains only to make clear that in finding these statutes pernicious and unconstitutional I do not mean to criticize anyone who believes, whether because of religious conviction, nonsectarian moral conviction, or simply a prudential belief that upholding the sacredness of human life whatever the circumstances is necessary to prevent us from sliding into barbarism, that abortion is always wrong and perhaps particularly so in late pregnancy, since all methods of late-term abortion are gruesome. If a woman told by her physician that her fetus will

be a Down's baby or a Tay-Sachs baby or will be born without arms or legs, or that her own health or even life will be endangered if she carries the fetus to term, decides nevertheless against abortion, I would be the last to criticize her decision. I might consider her a heroine or a saint. But what is at stake in these cases is whether the people who feel that way are entitled to coerce a woman who feels differently to behave as they would in her situation. The Constitution as interpreted by the Supreme Court in decisions that we are not free to palter with answers this question "no." We should therefore affirm the district court's decision in *Hope* and reverse the district court's decision in *Doyle*.

A true Copy:

Teste:

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Supreme Court, U.S.
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No. 99-830

In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

SUPPLEMENTAL APPENDIX TO PETITION FOR WRIT OF CERTIORARI

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Leroy CARHART, M.D., on behalf of himself and his patients obtaining abortions, Plaintiff,

v.

Don STENBERG, in his official capacity as Attorney General for the State of Nebraska; Mike Munch, in his official capacity as County Attorney for Sarpy County and as a representative of all county attorneys in Nebraska; Gina Dunning, in her official capacity as Director of Regulation and Licensure of the Nebraska Department of Health and Human Services; and Charles Andrews, M.D., in his official capacity as Chief Medical Officer of Nebraska, Defendants.

No. 4:97CV3205.

United States District Court,
D. Nebraska.

July 2, 1998.

Simon Heller, David Gans, The Center for Reproductive Law & Policy, New York City, Jerry M. Hug, Alan G. Stoler, Omaha, NE, for Plaintiff.

Don Stenberg, Attorney General, Steve Grasz, Deputy Attorney General, James D. Smith, Assistant Attorney General, Lincoln, NE, for Defendants Don Stenberg, Gina Dunning, Charles Andrews.

Tamra L. Walz, Deputy Sarpy County Attorney, Papillion, NE, for Defendant Mike Munch.

MEMORANDUM AND ORDER

KOPF, District Judge.

Because the State of Nebraska has imposed an undue burden on Dr. Carhart and his patients by adopting and

threatening to enforce a vague "partial-birth" abortion law, I shall declare the law unconstitutional as applied to Dr. Carhart and his patients. I will also permanently enjoin enforcement of Nebraska's law against the doctor and his patients (and those who are similarly situated). However, I do not reach the question of whether the law is facially invalid. Pursuant to Federal Rule of Civil Procedure 52(a), my reasons for this decision are set forth below.

I. FINDINGS OF FACT

A. The Parties

1. Plaintiff LeRoy Carhart, M.D., practices medicine and surgery in Nebraska and performs abortions in Bellevue, Sarpy County, Nebraska. (Filing 1, Compl., at 3; Filing 9, Stenberg and Thomas Answer, at 2; Ex. 16, Carhart Curriculum Vitae, at 1, 5.)

2. Carhart received his Doctorate of Medicine in 1973; completed his internship at Malcolm Grow USAF Hospital at Andrews Air Force Base, Maryland, in 1974; and completed his general surgery residency at Hahnemann Medical College and Hospital in Philadelphia, Pennsylvania, and Atlantic City Medical Center in Atlantic City, New Jersey, in 1978. Carhart is a retired lieutenant colonel in the United States Air Force who served as chief of general surgery, chief of emergency medicine, and chairman of the department of surgery at Offutt Air Force Base in Nebraska from 1978 to 1985. As part of his

duties at Offutt, Carhart supervised 20 to 25 other physicians, including obstetricians and gynecologists. (Tr.[1] 193:25-194:5.) Carhart has been an assistant professor in the surgery departments of both Creighton University School of Medicine and the University of Nebraska Medical Center. (Ex. 16, Carhart *Curriculum Vitae*, at 2-4.) Since 1985 Carhart has operated a general medical practice with a specialized abortion facility.[2] (Tr. 82:14-21.) He performs 800 abortions each year. (Tr. 83:3.) Carhart has never attempted to become certified by a medical specialty board and currently has no hospital privileges. (Tr. 139:2-25.) He is licensed to practice medicine in eight states. (Ex. 16, Carhart Curriculum Vitae, at 5.)

3. Defendant Don Stenberg is attorney general of the State of Nebraska. Defendant Gina Dunning is director of the Nebraska Department of Health and Human Services Regulation and Licensure. (Filing 1, Compl., at 3-4; Filing 9, Stenberg Answer, at 2; Order on Final Pretrial Conf. at 2.) Defendant Mike Munch is the elected county attorney for Sarpy County, Nebraska, and is responsible for the enforcement of criminal law within

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[1] "Tr." denotes the transcript from the hearing on the preliminary injunction. *See Carhart v. Stenberg*, 972 F.Supp. 507 (D.Neb.1997) (granting preliminary injunction) (*Carhart I*). Pursuant to Fed.R.Civ.P. 65(2), the parties agreed that the testimony and exhibits received in evidence at the hearing on the preliminary injunction were admissible at the trial on the merits as part of the trial record and need not be repeated at trial. (Order on Final Pretrial Conf., at 3.)

[2] Carhart learned to perform abortions on rotation in a civilian hospital while on active duty with the Air Force. He was not permitted to perform abortions in Air Force hospitals. (Tr. 194:6-15.)

Sarpy County. (Filing 1, Compl., at 3-4; Filing 11, Munch Answer, at 1.) Defendant Charles Andrews, M.D., is the Chief Medical Officer for Nebraska who has disciplinary authority over medical license holders in Nebraska, pursuant to Neb.Rev.Stat. § 81-3201 (Michie Supp.1997).

B. Legislative Bill 23

4. On June 3, 1997, the Nebraska Unicameral passed Legislative Bill 23 ("LB 23") with an emergency clause making it effective upon the governor's signature on June 9, 1997. (Ex. 6.) On August 14, 1997, I enjoined Defendants from enforcing LB 23 against Dr. Carhart "regarding his performance of D & X abortions on nonviable fetuses." (Filing 19 at 58.)

5. Legislative Bill 23 prohibits "partial-birth abortions" in the State of Nebraska "unless such procedure is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." LB 23 § 3(1), codified at Neb.Rev.Stat. § 28-328(1) (Michie 1997).

6. Legislative Bill 23 defines "partial-birth abortion" as follows:

> Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. For purposes of this subdivision, the term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.

LB 23 § 2(9), codified at Neb.Rev.Stat. § 28-326(9) (Michie 1997).

7. Legislative Bill 23 makes the "intentional and knowing performance of an unlawful partial-birth abortion" a Class III felony, as well as grounds for automatic suspension and revocation of an attending physician's license to practice medicine in Nebraska. LB 23 § 3(2) & (4), codified at Neb.Rev.Stat. § 28-328(4) & (5) (Michie 1997).

8. "Partial-birth abortion" is not a recognized medical term. (Tr. 88:18-89:6, Carhart Test.; Tr. 216:3-13, Hodgson Test.)

C. Abortion Procedures

9. Carhart performs abortions in a clinic setting from a gestational age of 3 weeks until fetal viability,[3] with gestational age being measured from the first day of a woman's last menstrual period, as verified by ultrasound. (Tr. 83:9-84:5; 141:20-22.) Of the 800 women on whom Carhart performed abortions in 1996, 200 were

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[3] Carhart testified that fetal viability may occur around 22 weeks' gestation, but it can vary depending upon maternal habits such as drug and alcohol use and lack of prenatal care. (Tr. 174:17-175:7.)

past their 14th week of pregnancy. (Tr. 83:1-3; 185:14-24.) As far as he knows, Carhart is the only abortion provider in Nebraska who performs elective abortions past 16 weeks' gestation. (Tr. 132:10-18.)

10. If a woman wants an abortion after viability and the abortion is not medically indicated, Carhart refers the patient elsewhere. (Tr. 87:13-22.) If a patient comes to him for an abortion and "there is any concern of fetal viability," Carhart does not use his own judgment to determine viability, but instead insists on a specific referral from the patient's physician identifying fetal flaws, stating that the fetus is not viable, and stating that the patient needs an abortion. (Tr. 174:4-16.)

11. Carhart performs abortions on patients whose health, rather than life, would be preserved by having an abortion, such as those with severe renal disease, severe diabetes that has required hospitalization, and hyperemesis gravidarum, a condition characterized by constant vomiting throughout pregnancy such that the pregnant woman loses a good portion of her body weight. Carhart has also performed abortions on patients who indicated that if abortion had not been an option for them, they would have considered attempting a self-induced abortion or suicide. (Tr. 133:16-134:11.)

12. Carhart selects the abortion procedure he will use on various patients based on gestational age and other medical factors. (Tr. 84:6-12.)

13. The parties have stipulated to the admission of Exhibit 7, which is a portion of the American Medical Association's (AMA's) "Report of the Board of Trustees on Late-Term Abortion." The board of trustees prepared

and submitted the report to the AMA's board of delegates in May, 1997, in response to the passage of a 1996 resolution by the delegates calling for the AMA to conduct a study of late-term pregnancy termination techniques. (Filing 13 ¶ 2; Tr. 326:7-327:16.) Hereinafter, Exhibit 7 shall be referred to as the "AMA report."[4]

14. The parties have also stipulated to the admission of Exhibit 24, which is a January, 1997, statement of policy issued by the American College of Obstetricians and Gynecologists Executive Board on "intact dilatation and extraction."

1. Suction Curettage or Vacuum Aspiration

15. The AMA report indicates that suction curettage, or vacuum aspiration, is the most common means of inducing abortion from the 6th through the 12th week of gestation. (Ex. 7, at 7:29-30.) The AMA report describes this procedure as follows:

> Prior to the procedure a pelvic examination is done to determine the size and position of the uterus. A speculum is used to visualize the cervix, a local anesthetic such as a paracervical block is administered, and the cervix is then dilated using rigid dilators (e.g., the Pratt dilator). Osmotic dilators may be used prior to

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[4] Exhibit 3, a certified "rough draft transcript" of the floor debate on LB 23, and Exhibit 8, an informational booklet addressing fetal development entitled "If you are Pregnant . . . " which was prepared by the Nebraska Department of Health pursuant to state law, were also received into evidence, but not to prove the truth of the matters asserted therein. (Tr. 7:23-9:25.)

> the procedure. Once the cervix is sufficiently dilated, a suction tube is inserted and rotated inside the uterus to loosen and remove the contents. The suction tube may be attached to a suction machine or syringe. A curette may be used to scrape the endometrium, thereby ensuring the removal of any remaining tissue. These procedures are typically performed on an outpatient basis.

(Ex. 7, at 7:31-37 (footnotes omitted).)

16. Carhart uses curettage[5] with vacuum aspiration from approximately the 12th through the 15th week of gestation. Carhart stated that "[a]t about the 12th or 13th week, we usually use curettage with vacuum aspiration up through the 15th, 16th week, after that 16th week, generally, it's a dilation and evacuation procedure." (Tr. 84:20-23.) At another point, Carhart stated that the "14th to 15th week" was the latest he would use the curettage with vacuum aspiration procedure. (Tr. 93:12-14.) While Carhart attempts to use curettage with vacuum aspiration in the 14th and 15th weeks of gestation, "[m]ost of the time by the 15th week, it doesn't work," and he must "use a mechanical forcep to actually grasp the fetus and remove it." (Tr. 93:14-17.)

17. Carhart uses ultrasound while conducting the vacuum aspiration procedure. Ultrasound is "an adaption of the sonar developed by the Navy in the 1930's to find

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[5] Carhart describes curettage as a method of removing fetal debris, placental fragments, and potentially cancerous growths from the uterine wall, thereby reducing the risk of infection, greater bleeding, and passing fetal material into the mother's bloodstream. (Tr. 164:6-165:7.)

the different densities of substances, usually in comparison with a known substance." (Tr. 93:22-25, Carhart Test.) Ultrasound is used to display a picture of fetal tissue and cartilage on a television screen. (Tr. 94:1-5, Carhart Test.)

18. When the vacuum aspiration procedure is used, a fetus can come through the suction tube, or cannula, intact or dismembered. Carhart uses cannulas ranging from 5 to 16 millimeters. (Tr. 95:10-24; 96:2-8.) If the tube becomes clogged during this procedure Carhart must remove the tube to "declog" it, at which time the uterus will expel its contents into the vaginal cavity. (Tr. 155:18-20.)

19. The fetus is not dead before Carhart begins the vacuum aspiration procedure, and the entire fetus comes through the cannula alive in many instances. (Tr. 96:15-18; 97:16-17.)

2. Dilation and Evacuation (D & E)

20. According to the AMA report, the most common procedure for inducing abortion early in the second trimester of pregnancy, or in the 13th through 15th weeks of gestation, is dilation and evacuation, or D & E. (Ex. 7, at 8:1-10.) The AMA report describes the D & E procedure at 13 through 15 weeks' gestation as follows:

> Ultrasonography is used prior to the procedure to confirm gestational age, because the underestimation of gestational age can have serious consequences during a D & E procedure. D & E is similar to vacuum aspiration except that the cervix must be dilated more widely because surgical instruments are used to remove larger

> pieces of tissue. Osmotic dilators[6] are usually used. Intravenous fluids and an analgesic or sedative may be administered. A local anesthetic such as a paracervical block may be administered, dilating agents, if used, are removed, and instruments are inserted through the cervix into the uterus to remove fetal and placental tissue. Because fetal tissue is friable and easily broken, the fetus may not be removed intact. The walls of the uterus are scraped with a curette to ensure that no tissue remains.[7] In pregnancies beyond 14 weeks, oxytocin is given intravenously to stimulate the uterus to contract and shrink.

(Ex. 7, at 8:10-19 (footnotes omitted).)

21. According to the AMA report, the D & E procedure is also used from 16 to 24 weeks' gestation, with the following variations:

> Dilation and evacuation procedures performed in the mid- to late-second-trimester involve the preoperative use of laminaria or osmotic dilators (rather than surgical dilators) which are inserted in the endocervical canal in order to dilate the cervix. The procedure is usually performed under local anesthesia, using sedation

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[6] Carhart testified that the type of osmotic dilator he uses is seaweed that has been sterilized and medically prepared. He also referred to this osmotic dilator as laminaria. (Tr. 98:1-4; 99:1-3.) With this particular procedure, Carhart waits 12 to 72 hours before completing the abortion in order to allow for adequate dilation. (Tr. 98:6-14.)

[7] Carhart testified he also vacuum aspirates the uterus to ensure that no tissue fragments are left on the uterine wall. (Tr. 98:15-18.)

> and paracervical block. Intracervical vasopression is often used to minimize bleeding, and high dose oxytocin is administered intravenously prior to the procedure. Fetal tissue is extracted through the use of surgical instruments, followed by extraction of placental tissue and subsequent curettage. Because the fetus is larger at this stage of gestation (particularly the head), and because bones are more rigid, dismemberment or other destructive procedures are more likely to be required than at earlier gestational ages to remove fetal and placental tissue. Some physicians use intrafetal potassium chloride or digoxin to induce fetal demise prior to a late D & E (after 20 weeks), to facilitate evacuation.

(Ex. 7, at 8:28-38 (footnotes omitted).)

22. Carhart uses the D & E procedure "after that 16th week" of gestation, combined with prostaglandin to aid in cervical dilation and other medication to cause the uterus to contract. (Tr. 84:24-85:16.)

23. Carhart's method of mechanically removing the fetus from the uterus during D & E involves using ultrasound in order to observe the fetus and the surrounding area; using vacuum aspiration or forceps to rupture the membranes; and then grasping a portion of the fetus in order to bring it out of the uterus with long-handled forceps. (Tr. 100:1-14.) After the membranes are ruptured and the uterus begins to contract, a fetal extremity will often prolapse through the cervical os such that Carhart must dismember the extremity. He then attempts to bring the feet or skull down, dismembering the remaining arm or other extremities in the process. (Tr. 110:6-9; 118:9-12.)

24. When Carhart performs a D & E, he inserts an instrument inside the uterus, grabs a portion of the fetus, pulls it through the cervical os, and dismembers various fetal parts by the traction created between the instrument and the cervical os. (Tr. 116:2-10.) The tearing of fetal parts from the fetal body is accomplished by means of traction at the cervical os.[8] Dr. Carhart described the procedure in response to counsel's questions as follows:

> Q When you are doing a D & E that involves dismemberment, where does the dismemberment occur; in other words, do you insert instruments into the uterus and dismember the fetus inside the uterus, or do you dismember it in some other way?
>
> A Well, we insert one instrument inside the uterus, grab a portion of the fetus and pull it through the cervical os. The dismemberment occurs between the traction of . . . my instrument and the counter-traction of the internal os of the cervix. I suppose you could put two instruments in the uterus and try to dismember it. I think that would be very dangerous.
>
> Q So the dismemberment occurs after you pulled a part of the fetus through the cervix, is that correct?
>
> A Exactly. Because you're using – The cervix has two strictures or two rings, the internal os and the external os, and you have – that's what's actually doing the dismembering. It's like who is pulling the cat's tail. If you are

[8] The cervical os is the mouth or opening of the cervical canal. STEDMAN'S MEDICAL DICTIONARY 996 (4th unabridged law. ed.1976).

holding it and the cat's pulling it, something has to pull the other way. Otherwise, if you drag a string across the floor, you'll just keep dragging it. It's not until something grabs the other end that you are going to develop traction.

Q When we talked before or talked before about a D & E, that is not – where there is not intention to do it intact, do you, in that situation, dismember the fetus in utero first, then remove portions?

A I don't think so. . . . I don't know of any way that one could go in and intentionally dismember the fetus in the uterus. If you grab an extremity and twist it, you can watch the whole fetus just twist. It takes something that restricts the motion of the fetus against what you're doing before you're going to get dismemberment.

> Q When you pull out a piece of the fetus, let's say, an arm or a leg and remove that, at the time just prior to removal of the portion of the fetus, is the fetus alive?
>
> A Very often, yes, sir.

(Tr. 116:2-117:13.)

25. Carhart's description of this procedure is consistent with that of Dr. Jane Hodgson, founding fellow of the American College of Obstetrics and Gynecology, past president of the Minnesota Ob/Gyn Society, and author of 50 to 100 published articles on abortion. (Tr. 196:16-24; 197:11-13; Ex. 14, Hodgson Curriculum Vitae, at 2.)[9]

[9] Dr. Hodgson received her M.D. and M.S. in obstetrics and gynecology from the University of Minnesota School of

26. Through the 19th week of gestation, ultrasound confirms, by indicating a fetal heartbeat, that the fetus is "invariably" alive when Carhart performs a D & E, and via ultrasound Carhart has observed fetal heart activity with "extensive parts of the fetus removed." (Tr. 100:15-22; 109:4-23; 110:12-14; 119:2-9; 195:9-11.) Dr. Hodgson also testified that the fetus may still have a heartbeat while extremities are being removed. (Tr. 211:4-7.)

3. Intact Dilation and Evacuation (Intact D & E or D & X)

a. The Procedure

27. In an effort to minimize perforation of the uterus or cervix by instruments used during a D & E or from piercing caused by fetal parts, some physicians use "a form of D & E that has been referred to in the popular press as intact dilation and extraction (D & X)." (Ex. 7, at 8:40-42.)

Medicine; completed her internship and residency at the Jersey City Medical Center in New Jersey; and completed a fellowship in obstetrics and gynecology at the Mayo Clinic in Rochester, Minnesota. (Ex. 14, Hodgson *Curriculum Vitae*, at 2.) Dr. Hodgson has performed or supervised at least 30,000 abortions as the director of numerous medical clinics throughout the country since 1973, and has delivered at least 5,000 babies. (Tr. 197:14-20.) Dr. Hodgson has been a board member of Planned Parenthood, belongs to the National Abortion Federation and the Abortion Rights Council, and is currently a board member for the Center For Reproductive Law & Policy, for whom Plaintiff's lawyers also work. (Ex. 14, Hodgson *Curriculum Vitae*, at 3.)

28. For any abortion "over 15 weeks[']" gestation, Carhart intends and prefers to remove the fetus intact by using the intact D & E procedure, although it is "usually the 19th and 18th and early 20-week fetuses that come out intact." (Tr. 100:9-10; 101:3-5; 184:1-23.)

29. Citing the American College of Obstetricians and Gynecologists' (ACOG) January, 1997, statement on intact dilation and extraction, the AMA report describes the intact D & X as "deliberate dilation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus." (Ex. 7, at 8:42-46; Ex. 24.)[10]

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[10] The ACOG statement of policy on intact dilatation and extraction states that "unless all four elements [dilatation of cervix, instrumental conversion of fetus to footling breach, breech extraction of body excepting head, and partial evacuation of intracranial contents of living fetus to effect vaginal delivery of dead, but otherwise intact, fetus] are present in sequence, the procedure is not an intact D & X." (Ex. 24.) The policy statement states that the intact D & X is one method of terminating a pregnancy after 16 weeks' gestation, and concludes that:

> Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the only option to save the life or preserve the health of the woman. An intact D & X, however, may be the best or most appropriate procedure in a

30. In contrast to the AMA's and ACOG's description of the intact D & E or D & X procedure, Carhart does not perform instrumental conversion of the fetus to a footling breech, but removes the fetus headfirst or feet first, depending on how the fetus is positioned. (Tr. 102:19-24; 111:3-6; 156:18-157:19.) Carhart prefers the feet-first presentation because less dilation is required and "that's the absolute safest scenario." (Tr. 192:18-193:2.)

31. When Carhart performs this procedure, he drains the amniotic fluid before beginning the evacuation procedure in order to avoid amniotic fluid embolus, which he views as a serious and common cause of maternal death or complications. (Tr. 102:1-6.) If possible, Carhart then attempts to grasp and divide the umbilical cord of the fetus, which is the structure that transports arterial and venous blood between the fetus and the placenta, giving the fetus its only source of oxygen. If he divides the cord, the fetus will usually die within 6 to 10 minutes. (Tr. 111:11-20; 189:20-24.) There are instances in which Carhart cannot divide the cord because he is unable to reach it due to fetal position or spontaneous protrusion of

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> particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women. The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.

(Ex. 24 (bold in original).)

a fetal part through the cervical os, preventing access to the cord. (Tr. 111:21-25; 190:17-25.)

32. If Carhart succeeds in dividing the umbilical cord, he does not wait for fetal death to occur before continuing the procedure because once the membranes have been ruptured and drugs administered to induce contractions, each minute of delay causes maternal blood loss. (Tr. 190:2-16.)

33. When the fetus is presented feet first, Carhart, using forceps, pulls the feet of the living fetus from the uterus into the vaginal cavity and then pulls the remainder of the fetus, except the head, into the vaginal cavity to a point where the base of the fetal skull is lodged in the uterine side of the cervical canal. (Tr. 110:19-22; 112:2-12.) At that point, the size of the head will not permit him to pull it through the cervical canal into the vaginal cavity. To decompress the fetal skull and evacuate the contents in order to pull it through the cervical canal, Carhart uses an instrument to either tear or perforate the skull to allow insertion of a cannula and removal of the cranial contents. Sometimes he will crush the skull rather than pierce it in order to reduce the size of the skull. (Tr. 104:2-6; 112:13-16.) Brain death occurs sometime during this two- to three-second reduction procedure, but fetal heart function may continue for several seconds or minutes after the fetus's skull is decompressed. (Tr. 112:17-113:7.)

34. While he intends to remove the fetus intact for any abortion performed past 15 weeks' gestation, only about 5 or 10 percent of the fetuses Carhart aborts are delivered totally intact due to softness of the fetal tissue

such that it is easily fragmented. Carhart normally cannot perform this procedure before the 16th week of gestation because the fetal body parts tear apart during the process. (Tr. 115:9-18; 184:10-19.)

35. Some patients have requested that Carhart perform an intact D & E for personal reasons, and some physicians have asked to have the fetus as intact as possible for genetic study when the entirety of fetal deformities is unknown. (Tr. 123:9-25.)

b. Fetal Death

36. After the 20th week of gestation, Carhart attempts to induce fetal death 48 to 72 hours before beginning the abortion procedure with an ultrasound-guided intracardiac fetal injection of digoxin and lidocaine, both of which reduce and stop cardiac activity. (Tr. 119:10-25.) Carhart attempts to inject the drugs through the mid-line of the maternal abdomen where there are fewer blood vessels and he is less likely to encounter colon or small bowel contents. (Tr. 186:14-23.) Carhart attempts to inject the fetal thoracic cavity or heart, whereupon fetal death will occur within 15 to 20 minutes, but sometimes is able to inject only the amniotic sac, causing fetal death approximately 24 hours later. (Tr. 187:1-6.)

37. Carhart attempts to induce fetal death in this manner to achieve softness and compression of the fetal tissue and skull and to provide mental comfort to his patients. (Tr. 120:2-19.)

38. Carhart does not attempt to induce fetal demise in this manner during the 16- to 20-week time frame

because the waiting time between the injection and performance of the procedure is only 12 to 24 hours, and not much fetal tissue change occurs; Carhart finds that many of his patients in the earlier stages of pregnancy are more apprehensive of the fetal injection; and in the earlier stages of pregnancy, the uterus is smaller and the risks of the needle penetrating the bowel and of missing the fetus and injecting the medication into maternal circulation are greater. (Tr. 120:20-122:3; 188:2-11.) Furthermore, Carhart sees patients for whom digoxin and lidocaine are medically contraindicated during any part of their pregnancy, such as those who have seizure disorders,[11] heart disease, or who are already taking either medication such that an injection would exceed the maximum recommended dosage. (Tr. 122:20-123:4.)

39. Dr. Hodgson testified that in all forms of abortion, the point at which fetal demise occurs is "extremely variable." (Tr. 217:17-18.) In her opinion, lack of fetal heartbeat is the best available measure for determining fetal demise, and fetal death by that measurement can be quite protracted. (Tr. 219:16-25.)

c. Benefits of the Intact D & E or D & X

40. The AMA report states that "[t]his procedure may minimize trauma to the woman's uterus, cervix, and other vital organs. Intact D & X may be preferred by some

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[11] Carhart testified that lidocaine can induce seizures in people, so treating someone who has a seizure disorder with a medication that could trigger further seizures would be an "additional risk." (Tr. 170:16-171:1.)

physicians, particularly when the fetus has been diagnosed with hydrocephaly or other anomalies incompatible with life outside the womb." (Ex. 7, at 8:46-49.)

41. Carhart's intent to remove the fetus intact for any abortion performed past 15 weeks' gestation is aimed at reducing the chances of maternal complications or death. (Tr. 100:9-10; 101:7-102:6; 124:16-125:2.) Intact removal of the fetus lowers maternal complications by preventing sharp fragments, such as pieces of long bone or skull fragments, from passing through the cervical os without some kind of covering or protection. When the fetus is removed intact, its bones are covered by fetal tissue, causing less trauma to the cervix. (Tr. 101:3-16; 131:1-7.)

42. Carhart also stated that intact removal of the fetus minimizes the risk of damage to maternal structures from repeated use of instrumentation in the uterine cavity. (Tr. 107:18-108:13; 131:1-23.) The more times Carhart must enter the uterus with an instrument, the more the complication rate multiplies. (Tr. 179:13-22.) The intact D & E or D & X procedure involves fewer insertions of forceps or other foreign objects into the uterus than a D & E resulting in dismemberment of the fetus. (Tr. 179:23-180:2.)

43. Performing the intact D & E or D & X procedure also allows a more accurate assessment of whether the uterine cavity has been emptied. Fetal and placental debris remaining in the uterus – as is possible with a D & E involving dismemberment – can cause infection, greater bleeding, and risk of absorption of the fetal tissue into the

maternal bloodstream, as explained in more detail below. (Tr. 165:4-10; 183:4-24.)

44. Dr. Hodgson described leaving fetal parts in the uterus as a potentially "horrible complication" that can cause infection and often results in perforation of the uterine wall by bony splinters. (Tr. 211:19-24.)

45. Carhart's method of intact removal of the fetus and evacuation of the contents of the fetus's brain when it is reachable through the cervical os directly outside the uterus also helps prevent "disseminated intravascular coagulopathy" (DIC), that is, the absorption into the mother's bloodstream of fetal brain, skin, and blood tissue through the blood sinuses or cavities in the uterine wall, thereby causing the mother's own coagulation factors to stop working. According to Carhart, DIC is another cause of maternal death or complications, with the risk of such a complication being less than 1 in 1,000. (Tr. 101:16-25; 102:7-14; 158:13-159:14.) Compression of the fetal skull also enables Carhart to obtain as little cervical dilation as possible in order to reduce other maternal complications, such as incompetent cervix, at a later date. (Tr. 103:2-17.)

46. In Carhart's opinion, performing an intact D & E is much safer than performing a D & E that does not result in removal of an intact fetus. (Tr. 108:14-18.) Although she has not intentionally[12] performed an intact

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[12] Dr. Hodgson described it as a "victory" when an intact fetus is removed during a D & E without the intent to do so. (Tr. 211:8-12.)

D & E, Dr. Hodgson believes the procedure is a technological advance that has received favorable reports from those who are performing the procedure. (Tr. 212:8-22.) Dr. Hodgson believes the D & X procedure is "an advance in technology" because by removing the fetus intact there is "less instrument manipulation," which means, "of course, the higher your safety." (Tr. 212:4-22.)

d. Number of Intact D & Es or D & Xs Performed by Carhart in Which Fetal Life Could Not be Terminated Before Delivery

47. In 1996, Carhart had 180 to 190 patients with a live fetus in utero for whom it was medically inadvisable to inject digoxin and lidocaine to terminate the life of the fetus and on whom he began what he intended to be an intact D & E. (Tr. 189:1-12.) Of those 180 or 190 patients, Carhart removed approximately 20 fetuses intact, and 10 of those 20 presented themselves feet first. (Tr. 191:10-22.)

4. The Haskell D & X

48. In *Women's Medical Professional Corp. v. Voinovich*, 911 F.Supp. 1051 (S.D.Ohio 1995) (*WMPC I*), *aff'd*, 130 F.3d 187 (6th Cir.1997) (*WMPC II*), *cert. denied*, ___ U.S. ___, 118 S.Ct. 1347, 140 L.Ed.2d 496 (1998), the court considered the constitutionality of an Ohio law banning the use of the so-called "Dilation and Extraction"

(D & X) procedure.[13] One of the plaintiffs, Dr. Martin Haskell, used a method of abortion from 20 to 24 weeks' gestation characterized by various parties in this case as the D & X procedure[14] and performed as follows:

> On the first and second days of the procedure, Dr. Haskell inserts dilators into the patient's cervix. On the third day, the dilators are removed and the patient's membranes are ruptured. Then, with the guidance of ultrasound, Haskell inserts forceps into the uterus, grasps a lower extremity, and pulls it into the vagina. With his fingers, Haskell then delivers the other lower extremity, the torso, shoulders, and the upper extremities. The skull, which is too big to be delivered, lodges in the internal cervical os. Haskell uses his fingers to push the anterior cervical lip out of the way, then presses a pair of scissors against the base of the fetal skull. He then forces the scissors into the base of the skull, spreads them to enlarge the opening, removes the scissors, inserts a suction catheter, and evacuates the skull contents. With the head

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[13] The citation and the description of Haskell's procedure are offered as an explanation since various witnesses spoke about Dr. Haskell's procedure during the trial of this case. The court has not used these decisions or the evidence presented in *WMPC I* to satisfy the plaintiff's burden of proof.

[14] A variant of the procedure was also used extensively by Dr. James McMahon before his death in 1995. *See Partial Birth Abortion Ban, 1995; Hearings on H.R. 1833 Before Senate Judiciary Committee*, 104th Cong. 1st Sess., *available in Westlaw* 1995 WL 685998 (F.D.C.H.) (database USTESTIMONY) (statement of Dr. Mary Campbell) (Nov. 17, 1995) (describing her observations of the procedure used by Dr. McMahon). *See also* n. 13, *supra*.

decompressed, he then removes the fetus completely from the patient.

Id. at 1066 (footnotes omitted). Dr. Haskell routinely cuts the umbilical cord before penetrating the skull with scissors. *Id.* at 1066 n. 17.

5. Labor Induction

49. Labor induction, an alternative to D & E and what has been described above as the intact D & E or D & X, may also be used to induce abortion during the 16th to 24th week of gestation. Labor may be induced by use of hypertonic solutions such as urea or saline, or prostaglandin. (Ex. 7, at 9:1-4.)

50. The use of saline to induce labor requires insertion of a needle through the abdomen and injection of the amniotic sac with a concentrated salt solution, which causes fetal demise and induces uterine contractions. Over a period of several hours, the uterine contractions cause dilation of the cervix and expulsion of the contents of the uterus. (Ex. 7, at 9:5-8.)

51. Urea is a nitrogen-based solution that causes fetal demise when injected into the amniotic sac and is typically followed by administration of prostaglandin to induce uterine contractions which will expel the contents of the uterus. (Ex. 7, at 9:8-12.)

52. Carhart does not perform saline or prostaglandin induction, and he does not perform inductions at all during the second trimester of pregnancy because he believes induction is medically contraindicated as a method of abortion. (Tr. 86:2-7; 125:3-126:1; 126:18-19.)

Carhart believes induction during the second trimester is too uncontrolled – that is, the procedure can take over a week to complete; women have reactions to the drugs used during the procedure; and a segment of the population cannot undergo induction because of medical conditions such as hypertension, heart disease, or diabetes. (Tr. 125:6-126:1.) Carhart is aware of other physicians in Nebraska who perform abortions by induction, but only for maternally or fetally indicated abortions. (Tr. 126:2-4; 132:1-9.)

53. According to Stanley K. Henshaw, deputy director of research at the Alan Guttmacher Institute (AGI) in New York, statistical studies with which he is familiar indicate that abortions by induction are performed primarily in a hospital setting.[15] (Tr. 74:20-25; 76:20-22.) The Centers for Disease Control and Prevention (CDC) recognizes the accuracy of the data AGI collects. (Tr. 46:8-21 .)

6. Hysterotomy and Hysterectomy

54. Other abortion procedures available, but not routinely used, during 16 to 24 weeks' gestation are

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[15] Dr. Henshaw received his Ph.D. in sociology from Columbia University and his A.B. in physics from Harvard. The Alan Guttmacher Institute is a nonprofit corporation for research and public education on issues relating to reproductive health services. (Ex. 15, Henshaw *Curriculum Vitae*, at 1; Tr. 44:15-25.) Dr. Henshaw has written approximately 40 to 50 articles on studies he has conducted related to abortion, and his studies have included secondary analysis of existing data. (Tr. 45:9-17.) Dr. Henshaw has been a member of the National Abortion Federation. (Ex. 15, Henshaw *Curriculum Vitae*, at 2.)

hysterectomy and hysterotomy. According to the AMA report, "maternal mortality and morbidity associated with these procedures are significantly greater than those associated with other procedures used to induce abortion." (Ex. 7, at 9:14-16.)

55. Hysterotomy is major surgery and must be performed in a hospital setting. General anesthesia or anesthesia administered by epidural or spinal injection is necessary. The procedure consists of surgical delivery of the fetus through an incision in the abdomen and uterine wall, after which the fetus is removed, the umbilical cord cut, and the placenta removed. (Ex. 7, at 9:16-20.)

56. Hysterectomy "is appropriate in cases in which there is a preexisting pathology, such as large leiomyomas or carcinoma in situ of the cervix." (Ex. 7, at 9:20-22.)

57. Carhart does not perform hysterotomy or hysterectomy as methods of abortion, but he is aware of other physicians in Nebraska who perform abortions by these methods when an abortion is maternally or fetally indicated. (Tr. 86:2-9; 127:17-23; 132:1-9.)

D. Dr. Stubblefield

58. Dr. Phillip Stubblefield testified on behalf of the plaintiff regarding his experience teaching and performing abortions, the various available methods of abortion, and the risks involved with these abortion methods.

(Tr.2d[16] 6:20-91:17.) Dr. Stubblefield is currently a professor and Chairman of the Department of Obstetrics and Gynecology at the Boston University School of Medicine, as well as Chief of Obstetrics and Gynecology at the Boston Medical Center. He received his B.A. from Harvard College in 1962 and his M.D. from Harvard Medical School in 1966. Dr. Stubblefield was an intern in surgery at the University of Michigan Hospital from 1966 to 1967, and a resident in obstetrics and gynecology at the Boston Hospital for Women from 1970 to 1973. He was certified by the American Board of Obstetrics and Gynecology in 1975 and has held numerous academic appointments from 1971 to the present. Dr. Stubblefield has published extensively in the areas of voluntary control of human fertility and the prevention of premature birth, has served on five editorial boards for medical journals, and has held a myriad of positions in professional societies.[17] (Ex. 29, Stubblefield *Curriculum Vitae*.)

59. Since 1973 Dr. Stubblefield has performed, taught, and supervised abortions on a regular basis, including vacuum curettage, D & E, and labor induction. (Tr.2d 10:11-11:11; 13:7-20.) In his current position, he performs, supervises, or assists in 10 to 20 abortions per month. (Tr.2d 65:2-20.) When Dr. Stubblefield served as the Chief of Obstetrics and Gynecology at the Maine

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[16] "Tr.2d" denotes the transcript from the trial on the merits.

[17] These professional societies include the National Abortion Federation, The Planned Parenthood Association of America, and the American College of Obstetricians and Gynecologists.

Medical Center from 1988 to 1994, he primarily practiced and taught the D & E procedure through 22½ weeks of gestation. (Tr.2d 13:21-14:9.)

60. With regard to the various abortion procedures discussed in section (C) of this memorandum, Dr. Stubblefield testified that:

> *a. Suction Curettage or Vacuum Aspiration:* The suction tube (cannula) used to vacuum the pregnancy tissue from the uterine cavity is approximately 10 inches long and extends from within the woman's uterus to outside the woman's body. The fetus generally comes out of the uterus in fragments, but "it can come out intact," as when the physician overestimates the size of the uterus and uses a larger cannula than is necessary. (Tr.2d 19:11-20:21.) At the beginning of this procedure, the fetus is living, so fragments of a fetus, such as a leg or head, "can . . . come out while the fetus is still living," and the fetal heartbeat can continue after a portion of the fetus has been removed. (Tr.2d 20:22-21:19; 23:8-11.) If an intact fetus comes through the cannula, the fetus can remain living outside the woman's uterus for a short time. (Tr.2d 21:11-22:5.) While Dr. Stubblefield is not aware of an "agreed upon" definition of a "living" fetus where pregnancy termination is concerned, a beating heart is something that can be "objectively attest[ed] to" such that when "[w]e have an intact fetus with a heart beating, then the fetus is clearly alive." (Tr.2d 22:16-23:4; 68:10-23.) "[W]here we have an abortion in process . . . no one, to my knowledge, has tried to formally address what is living or not living in that context." (Tr.2d 69:2-5.)

> *b. Dilation and Evacuation (D & E):* Due to the risk of uterine tearing and perforation, dismembering a fetus in utero is "not done ." Instead, fetal pieces are removed from the uterus at the time they are detached from the rest of the fetus. (Tr.2d 30:7-31:11.) As with the suction curettage method, the fetus is living at the beginning of the D & E procedure; legs and arms can be removed from the fetus and uterus while the rest of the fetus remains in the uterus; and the remainder of the fetus left in the uterus could be "alive" for some amount of time. (Tr.2d 31:12-32:4.) It would be possible to perform the entire D & E procedure during ultrasound monitoring so that fetal heartbeat could be detected. (Tr.2d 23:12-21; 32:2-4.) The risks of performing a D & E are trauma to the uterus and cervix, such as laceration[18] and tearing caused by dilation or "pushing an instrument through . . . the wall of the uterus," resulting in injury to the bowel, bladder, or other nearby organs; extensive blood loss in situations where the uterus "does not contract well"; and "rare, very serious complications" like amniotic fluid embolism[19],

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[18] According to Dr. Stubblefield, "Because the uterus is large and soft, it takes some skill to avoid perforation. . . . [I]f one perforates, one can cause extensive harm. One can badly injure the bowel or bladder or the nearby organs, cause major blood loss and clearly major injury that will have to be surgically repaired with a major surgical procedure." (Tr.2d 32:12-17.)

[19] Dr. Stubblefield described amniotic fluid embolism as a complication that occurs in one in 10,000 cases and is "usually fatal, where tissue from the fetus enters the mother's circulation through the big venous openings inside the uterus and travel[s] through her body to the lungs where they cause major troubles." (Tr.2d 32:23-33:4.)

disseminated intravascular coagulopathy[20], and infection caused by retained pregnancy tissue. (Tr.2d 32:5-33:20.)

c. Intact Dilation and Evacuation (Intact D & E or D & X): Physicians who perform surgical abortions after 20 weeks of gestation modify the D & E procedure "to make it easier to perform and safer for the pregnant woman" since at this gestational age the fetus is larger and more rigid because "[t]he bones are now ossified and are no longer soft cartilage." (Tr.2d 34:17-24.)

(i) One modification of the D & E is the intact D & E, which involves administering successive sets of laminaria dilators and medication that causes the uterus to contract.

> Then depending on how the fetus presents, either through procedures as performed, if the fetus is presenting head first, which is probably more often the case, one can insert an instrument into the fetal skull and allow the brain content to come out. The head then collapses, and one then can pull the whole fetus out of the uterus immediately, and then reach up and pull the placenta out, and the procedure is done very quickly with very little blood loss, very little risk to the mother of perforation.

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[20] Dr. Stubblefield described disseminated intravascular coagulopathy as a complication "where tissue from the fetus, smaller amounts, perhaps, enter the circulation of the mother, trigger clotting within her blood system that uses up the clotting factors, exhausts their supply, so that the patient then begins to bleed heavily and will require a treatment of blood products in order to replenish the clotting factors and stop the bleeding." (Tr.2d 32:18-33:12.)

(Tr.2d 35:1-23.) Dr. Stubblefield has used the intact D & E procedure with head compression in a case where the fetus was already dead before the procedure began. (Tr.2d 39:19-40:1.) Dr. Stubblefield described the case in which he used this procedure:

> This was a patient referred to us who had a rare, awful complication of an amniocentesis done for genetic indications. We had an amniocentesis done outside of our center to diagnose Downs Syndrome for which she was at risk because of advanced age, and in retrospect, we know that the needle went through the intestine of the mother. The patient presented to another hospital about 48 hours after the amniocentesis in advanced infection, very severe infection with a lung disease and kidney disease resulting. She was transferred to our facility, and we were faced with the difficult situation of trying to stabilize this woman with advanced sepsis and then evacuate the uterus which was the source of the infection, and this is the case where I personally did a variation of intact D & E. We, in the intensive care unit, started intravenous Oxytocin to make the uterus contract, put several laminaria tents into the cervix to cause it to dilate, and then about five hours later moved her to the operating room, removed the laminaria, and I was relieved to see the cervix had dilated quite a bit, and the fetal head was presenting. I was able to just put an instrument called a t[e]naculum which is the sharp end on the fetal head, piercing it, and the brain tissue came out, and the fetus then came out and the placenta came out.

> The fetus had died a little bit before that. The mother got somewhat better after our procedure but was still seriously ill the next day, and we determined that her only chance of survival lay in us removing the uterus, so we did extract it the following day. Indeed, there was an abscess, a collection of pus within the wall of the uterus where the needle had entered the uterus, and it had gone through the bowel. The woman did survive. She was in intensive care . . . for six weeks but did survive, so certainly, her fertility was at risk, and she lost it.

(Tr.2d 44:13-46:6.)

This method of the intact D & E procedure – a "recent development" – involves less use of instruments than the "standard D & E involving fragmentation." (Tr.2d 40:2-23.) "It makes sense to think that doing the [intact D & E] would make it easier to evacuate the uterus without as many insertions of the instruments, and that . . . , theoretically, would be safer. It would be a while before we have the data to compare to say how important that really is, but [the success rate of this procedure, as reported in presentations by physicians who perform the procedure, demonstrate] a very impressive record for a late abortion procedure." (Tr.2d 40:23-41:6.) "If there are less manipulations within the uterus, less fetal tissue within the uterus less, specifically brain tissue within the uterus that enter the mother's circulation, [there is] less risk of" the "rare but devastating complications of the blood clotting abnormality, the DIC and the still less common amniotic fluid embolism." (Tr.2d 61:13-62:4.) Dr. Stubblefield noted that the risk of leaving pregnancy tissue in the uterus is possible during the intact D & E

procedure because a portion of the placenta could be left behind, but he has no reason to believe that the intact D & E procedure is less safe than the standard D & E procedure or labor induction at equal gestational ages. (Tr.2d 41:7-42:12; 62:13-23.) In fact, at advanced gestational ages, the intact D & E poses less risk of lacerating the cervix with skull or long bone pieces than does the standard D & E, which involves piece-by-piece removal of the fetus.

Dr. Stubblefield stated that "the surgeon . . . whose goal is to perform an intact D & E often finds that he cannot, that the anatomy is just such that he cannot do it without avulsing pieces of the fetus." (Tr.2d 39:15-18.)

(ii) The alternative modification to the D & E "is the one which, in the lay press, has been called a partial-birth abortion." (Tr.2d 35:24-25.) Dr. Stubblefield described this procedure as follows:

> [T]he fetus is either presenting by the breech, that is, feet first or one converts it to a breech by reaching up with fingers or instruments, locating the feet, pulling them down, then pulls feet down, arms down, and then with traction so that the head is now just above the cervical opening, inserts an instrument, scissors into the skull, and lets the brain tissue come out or aspirates it with a cannula, and the head collapses, and the fetus is delivered. This is a technique that's evolved fairly recently.

(Tr.2d 35:25-36:9.) While it is always possible to injure "anybody doing fairly simple things," Dr. Stubblefield believes this procedure, as it has been described to him, allows the operator to view the base of the fetal skull at

the upper end of the cervical canal such that "[i]t's possible with direct vision to slide the instrument up between the operator's fingers to enter the fetal head." (Tr.2d 43:2-10.) Thus, this procedure is not "particularly risky to the maternal health." (Tr.2d 90:6-91:2; Ct.'s Ex. 1.) Dr. Stubblefield has not performed this procedure himself, nor has he viewed anyone else perform it. (Tr.2d 91:11-15.)

Dr. Stubblefield agrees with the January, 1997, statement of policy issued by the American College of Obstetricians and Gynecologists Executive Board on "intact dilatation and extraction" (Ex. 24), which states that the intact D & X "may be the best or most appropriate procedure" in some cases. (Tr.2d 49:1-6.) As far as safety of the D & X procedure is concerned, Dr. Stubblefield is not aware of any medical studies which compare the safety of the intact D & X to other abortion procedures or conclude that the D & X procedure is safer than other abortion procedures. (Tr.2d 75:11-14; 77:22-25.) In "every area of practice," it is not appropriate to do such safety comparisons until a surgical procedure has been perfected "to the point where it's useful." (Tr.2d 75:18-76:1.) Further, the medical acceptance of surgical procedures is not always achieved by orderly and controlled testing; for instance, "[o]pen heart surgery was not tested in a randomized, controlled way. People figured out how to do it. Patients lived, they kept doing it, got better at it." (Tr.2d 78:10-20.)

Dr. Stubblefield has added a description of the D & X procedure to a chapter he regularly writes and revises for *Dr. Nichols's Textbook of Gynecologic Surgery*, and he plans to teach the procedure at the teaching hospital with

which he is currently affiliated. (Tr.2d 74:6-11; 80:11-81:12.)

(iii) Dr. Stubblefield became aware of the above-described D & E variations in 1995 at a presentation by Dr. McMahon at a National Abortion Federation meeting. He also became familiar with these methods through a similar presentation by Dr. Haskell. (Tr.2d 70:7-25.) Dr. Stubblefield views these techniques as safe methods of abortion and he plans to use both methods himself. (Tr.2d 44:3-10.) He testified that head compression, as used in the intact D & E and D & X methods, is necessary because the fetal head is much larger than the cervix, which is only minimally dilated in order to lessen the risk of infection and bleeding. (Tr.2d 63:2-22.)

d. Labor Induction: The other procedure available "later in pregnancy" that does not involve the use of instruments inside the uterus is labor induction. The modern method of inducing labor is to administer prostaglandins intramuscularly or directly into the vagina, where they are absorbed into the system, causing labor to begin. With use of prostaglandins, the average abortion takes 15 to 16 hours, with some women aborting more quickly and others taking "much longer." The labor-induction process is a hospital procedure that involves "[s]trong uterine contractions, labor pains" for the woman seeking the abortion. (Tr.2d 37:14-38:17.) Labor-induction procedures are not always successful, and in such cases, a D & E is then characteristically performed after the failed labor induction. (Tr.2d 43:11-44:2.)

If a woman seeking an abortion has a fetus with severe hydrocephalus, or water on the

brain, the fetus' head will be "tremendously distended and swollen," so labor induction will not work. "The woman is not going to be able to expel that fetus until the fetus dies and the head begins to be depressed unless you decompress the head yourself." (Tr.2d 52:2-13.) Further, use of prostaglandins to induce labor is contraindicated in women with severe heart disease. (Tr.2d 52:14-24.)

e. Hysterotomy and Hysterectomy: Because these major surgical procedures pose a "risk to the mother [that is] many-fold greater" than other abortion techniques such as the vacuum curettage, D & E, or labor induction, these procedures are only used as an abortion method in exceptional circumstances, as when cervical carcinoma is found in a woman with an advanced pregnancy and a hysterectomy would "take care of both things at the same time." (Tr.2d 46:20-47:22.)

61. Dr. Stubblefield has observed a variety of reasons a woman may seek an abortion after 16 weeks' gestation, including a woman's delay in seeking an abortion due to her youth or other barriers; "[w]omen who are finally deciding to leave their abusive spouse"; and development of a serious maternal or fetal disease or malformation which was previously unknown. (Tr.2d 50:2-51:11.)

62. Geneticists and internal medicine specialists have requested that Dr. Stubblefield provide intact aborted fetuses to them "so that it's easy for the pathologist to examine the fetus and confirm the diagnosis" in cases of fetal malformation. (Tr.2d 51:12-20.) In the past, Dr. Stubblefield has declined such requests because he

felt that "in [his] hands, the D & E procedure was safer and easier on the woman than going through labor induction. Now that [the intact D & E] is available, were I in this circumstance now, I think I would try to provide the intact D & E." (Tr.2d 51:21-52:1.)

63. Dr. Stubblefield opined that the "only way . . . to avoid" delivering into the vagina a "living unborn child, or a substantial portion thereof," as stated in LB 23, is to either (1) perform a "significantly riskier" abdominal operation, such as hysterotomy or hysterectomy, so that "nothing is delivered into the vagina" or (2) cause fetal demise prior to beginning any abortion procedure in every case. (Tr.2d 56:16-23; 57:3-8.) With the latter option, one would perform an amniocentesis in an attempt to inject the fetus with potassium chloride or digoxin to stop the fetus' heart. The risks of such an injection are traversing the bowel and carrying bacteria from the bowel into the uterus, thereby causing a rapidly progressing infection, as in the case Dr. Stubblefield described above; spearing a blood vessel and causing significant bleeding; and inappropriate injection of the substances into the mother's bloodstream, causing danger to her. While causing fetal demise by injection is commonly done after 20 weeks' gestation in order to cause decomposition and softening of the fetus so it can be easily removed with instruments, "to [cause fetal demise] at eight weeks would be ridiculous. It would be hard to do, take great skill to do it. You couldn't do it predictably without injuring the mother." (Tr.2d 58:10-24.)

E. Dr. Riegel

64. Defendants presented Dr. Christopher Riegel, an obstetrician, gynecologist, and infertility specialist from Dallas, Texas, as an expert witness to challenge the testimony presented by Drs. Carhart, Hodgson, and Stubblefield, discussed in detail above. Dr. Riegel received his medical degree from the University of Texas in 1987 and completed a one-year internship in pediatrics at Children's Medical Center in Dallas in 1988 and a four-year internship and residency in obstetrics and gynecology at Parkland Hospital at the University of Texas before entering private practice in 1992. Dr. Riegel became board-certified in obstetrics and gynecology in 1995. (Tr. 232:13-234:9.)

65. Dr. Riegel does not perform abortions due to moral objections and claims to be familiar with abortion procedures, risks, complications, and contraindications only from reading technical bulletins and textbooks and by becoming, during his service as chief resident in labor and delivery, "acquainted with what goes on" in medically indicated induction abortions of fetuses having malformations incompatible with life. His experience consists of attending at abortions that were already in progress when he arrived to complete the procedure. (Tr. 236:7-8; 238:12-239:8; 274:15-20; 275:16-22; 277:4-17.) Dr. Riegel has never observed a D & E abortion because he has "chose[n] not to be associated with them." (Tr. 276:11-20; 276:23-277:3.) Dr. Riegel testified that the intact D & E or D & X procedure is not medically recognized and in fact "does not exist." (Tr. 295:17-297:25.)

66. Dr. Riegel testified it is generally medically accepted that a fetus is dead if its heart stops beating (Tr. 236:14-20); injection of potassium chloride or digoxin into the heart of a fetus to cause fetal demise is generally done at 19 weeks' gestation or more (Tr. 244:8-245:4); in the hands of a skilled operator, the risk of perforating the maternal bowel or injecting the mother with digoxin or potassium chloride during such a procedure is "inconsequential" (Tr. 245:9-22); the risk of complications for a mother with a preexisting seizure or heart disorder from using such an injection to cause fetal demise is nonexistent, "rare," "low," or "minuscule" (Tr. 247:22-249:22); there is no maternal medical advantage to injecting a substance into a fetus while it is in the uterus in order to kill the fetus before removing it (Tr. 250:3-22); there is no maternal medical advantage to partially delivering the fetus alive, killing it, and then completing delivery, with the latter scenario involving the "blind" use of a sharp instrument in the vagina accompanied by risk of damage to the urethra, bladder, vaginal wall, cervix, and uterus (Tr. 255:13-18; 256:6-257:24; 292:4-5); no type of fetal tissue or amniotic fluid should enter the mother's bloodstream (Tr. 259:4-9); beginning at 16 weeks' gestation, Dr. Riegel uses induction instead of D & E to remove dead fetuses from the uterus, and if the patient has heart disease, diabetes, renal disease, or a prior Cesarean section, he refers her to a high-risk obstetrician (Tr. 264:17-19; 266:1-24; 272:13-15; 293:15-23); since 1988 Dr. Riegel has delivered by induction 10 to 20 demised fetuses at 16 weeks' gestation or later (Tr. 303:24-304:5); and in his geographical area of practice, it is generally accepted that amniocentesis at 13 to 18 weeks' gestation is performed

only by high-risk obstetricians (Tr. 279:24-25; 284:25-285:5).

67. With regard to induction by prostaglandin injection, a process which requires hospitalization, Dr. Riegel described the side effects of nausea, vomiting, diarrhea, and fever that accompany the injections the patient receives every three hours and the 8- to 36-hour time frame the induction procedure requires. (Tr. 306:5-307:23.)

F. Dr. Boehm

68. Defendants' witness Dr. Frank Boehm received his B.A. and M.D. from Vanderbilt University in Tennessee in 1962 and 1965, respectively. He completed a surgery internship and obstetrics-gynecology residency at Yale-New Haven Hospital in Connecticut, as well as a six-month fellowship in surgery and oncology at City of Hope in Duarte, California. Dr. Boehm has had numerous academic and professional appointments; has served as an editorial consultant for seven medical journals; and has authored numerous articles, book chapters, books, abstracts, and presentations dealing with various issues in obstetrics and gynecology. Dr. Boehm is board-certified in obstetrics and gynecology and maternal fetal medicine, and he has practiced in those areas since 1966. He is a fellow of the American College of Obstetricians and Gynecologists, and is currently a professor of obstetrics and gynecology at the Vanderbilt University School of Medicine and Director of Obstetrics for the hospital. (Ex. 23, Boehm *Curriculum Vitae;* Ex. 32, Dep. of Dr. Boehm, at 3:1-3.)

69. In the past 25 years, Dr. Boehm has performed well over 100, but less than 1,000 abortions, with a focus on second-trimester, congenital-anomaly abortions involving serious malformations in the fetus. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 8:8-9:4.) Dr. Boehm does not perform abortions after 22 weeks and six days of gestation. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 13:21-14:11.) Dr. Boehm has performed the suction D & C, the D & E, labor-induction, and hysterotomy methods of abortion. He has not performed the intact D & E or D & X procedure, nor has he been present when other physicians have performed those procedures. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 15:16-16:16.) He has not performed a D & E abortion in 10 to 15 years. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 48:3-7.) In his current position, Dr. Boehm teaches the suction and sharp D & C, the prostaglandin abortion, and the hysterotomy as part of Vanderbilt's residency program. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 13:9-20.)

70. Dr. Boehm is not familiar with any studies that have evaluated the trauma to a woman's uterus, cervix, or other vital organs when the intact D & E or D & X procedures are used. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 16:8-17:8; 19:12-22.) Without data evaluating safety of the D & X procedure compared to other abortion procedures, Dr. Boehm does not believe the intact D & X abortion procedure is safer than other abortion procedures. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 23:22-24:17; 32:10-21.) Specifically, Dr. Boehm opined that choice of abortion technique does not to "any significan[t]" degree affect the risk of developing disseminated intravascular coagulopathy (DIC), and that amniotic fluid

embolus can occur "any time you are manipulating intrauterine cavity" – as would be the case when performing a D & C, D & E, Cesarean section, or labor and delivery – so selection of abortion method does not affect the risk of developing this condition. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 33:10-34:10; 34:11-35:15.) Dr. Boehm also testified as follows with regard to maternal safety when an entire fetus is removed intact during a D & E procedure:

> Q. [W]ould it be reasonable to conclude that by removing [a fetus] in one piece, there is less risk of leaving fetal tissue behind?
>
> A. Sure.
>
> Q. And would it be reasonable to conclude that there's less risk of sharp fetal fragments puncturing the uterus?
>
> A. Sure.
>
> Q. And therefore would it be reasonable to conclude that removing the fetus intact might be safer for the woman?
>
> A. Might be.
>
> Q. But you'd need a good study to determine whether it really was?
>
> A. I think that's a reasonable statement.

(Ex. 27, Videotaped Dep. of Dr. Boehm, at 45:1-46:1.)

71. Dr. Boehm believes there are safe alternatives to the intact D & E or D & X procedure, but "[h]ow safe [these procedures are] compared to other procedures is something that we really don't know because no one has ever done any research on partial birth abortion and compared it to other procedures. . . . So it's all theory. . . .

there are safe alternatives that have set some moral and ethical guidelines and work[ ] within a framework that I think is healthy for – more mentally healthy for the health care providers as well as for the patient." (Ex. 32, Dep. of Dr. Boehm, at 27:7-22.)

72. In response to plaintiff's counsel's question about abortion techniques that were commonly used shortly after *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973), in comparison to those used now, Dr. Boehm testified that the medical community no longer uses saline abortions because "[w]e have better techniques and techniques that are not associated with as high an incidence of problems. . . . I don't think anyone has compared saline with intravaginal prostaglandin which is what's used today, but I would think it's safer from what – this would be anecdotal experience over years of performing both, that the saline was not as safe as the intravaginal prostaglandin procedure." Although there were no statistical studies comparing the relative safety of these procedures, Dr. Boehm testified that he felt "comfortable making that transition" from one procedure to another. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 73:9-74:17.)

73. Dr. Boehm believes that the procedure contemplated by LB 23, and by a similar Tennessee law, "represents a departure from what is morally and ethically acceptable by the medical profession and especially those of us who agree with prochoice and who perform abortions." (Ex. 27, Videotaped Dep. of Dr. Boehm, at 32:4-9.) Dr. Boehm believes that legislative bills like LB 23 are "about as close as we can hope for in demonstrating to the public that the medical profession and the states are

willing to state certain moral and ethic[al] frameworks of how we offer and administer the process of abortion." Because there "is no medical need" for the procedure banned by LB 23 and "there are safe alternatives," it is Dr. Boehm's opinion that "such a procedure should be banned so as to comfort the general public in this country that abortions are not in the hands of callous extremists." (Ex. 27, Videotaped Dep. of Dr. Boehm, at 66:23-68:1; Ex. 25 at 2.)

74. Dr. Boehm testified that he understands the definition of "partial-birth abortion" as used in LB 23, and he believes a ban on such procedure would not pose an adverse medical risk to the health of any woman seeking an abortion because there are safe alternatives to such a procedure, such as labor induction. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 25:8-26:7.) Dr. Boehm testified that a prostaglandin induction abortion takes approximately 24 hours, and involves "[c]ontractions, cramps which we give epidurals for to reduce discomfort. They're in a labor bed. They have an intravenous going, running. We administer the prostaglandin intravaginally and wait for contractions, given them pain relief, and then they deliver." (Ex. 32, Dep. of Dr. Boehm, at 17:9-17.) Live 20-week fetuses have been born "alive . . . [t]hat is[,] the heart will be beating" during prostaglandin inductions. (Ex. 32, Dep. of Dr. Boehm, at 21:18-22.)

G. Credibility of Witnesses Giving Medical Testimony

75. Having observed the witnesses' demeanor and listened to their testimony, the court finds the testimony

of Drs. Carhart, Hodgson, Stubblefield, and Boehm to be credible based on their extensive training, experience, and knowledge of abortion procedures, whereas Dr. Riegel's testimony regarding abortion procedures is generally not credible. In particular, the court found Dr. Stubblefield particularly persuasive. He possessed the most extensive training, experience, and knowledge about the use and teaching of abortion procedures. These factors, coupled with his demeanor, made his testimony the most helpful. Putting aside each witness's views about the morality of abortion, the court's judgment of the strength of the witnesses' medical testimony is based solely on general indicia of credibility such as demeanor, candor, and each witness's training, experience, and knowledge about medicine in general and abortion in particular.

76. Dr. Riegel has never observed or performed a D & E. He has only completed medically indicated induction abortions of fetuses having malformations incompatible with life in situations where the abortion was already in progress when he arrived on the scene. This limited experience occurred when he was a medical resident. Furthermore, as the AMA report proves, (Ex. 7, at 8), Dr. Riegel was poorly informed regarding use of the intact D & E or D & X procedure when he stated that the procedure – which is, after all, the focus of this case – simply "does not exist." (Tr. 297:22-25.)

H. Statistical Risks and Frequency Associated With Abortion Procedures

77. Overall maternal mortality rates for the D & E, labor induction, and hysterectomy/hysterotomy methods of abortion at 13 weeks' gestation or later are 51.6 per 100,000 abortions for hysterectomy/hysterotomy, 7.1 per 100,000 abortions for labor induction, and 3.7 per 100,000 abortions for D & E. Mortality rates resulting from labor induction and D & E performed at 16 to 20 weeks are 7.9 and 6.5 respectively, and 10.3 and 11.9 respectively at 21 weeks or more. (Ex. 7, at 10, tbl. 4: Maternal Mortality Rates for Induced Abortion Procedures at 13 Weeks' Gestation or Later, U.S., 1974-1987.) The AMA report beginning the evacuation procedure summarizes these statistics as follows: "Maternal mortality rates, overall, are higher for labor induction than D & E (7.1 and 3.7, respectively), but mortality rates resulting from labor induction and D & E are comparable for induced abortions performed at 21 weeks or more (11.9 and 10.3)." (Ex. 7, at 9:39-41; 11:28-30.)[21] Dr. Hodgson stated that induction beyond weeks 18 to 20 "can be made as safe" as the D & E procedure resulting in dismemberment. (Tr. 212:1-3.)

78. While concluding that more systematic research is needed on complication rates associated with various

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[21] Carhart stated that the complicating effects of anesthesia use during induction were responsible for one-third of the total deaths occurring as a result of abortion. It is not clear whether this was factored into the AMA report's statistics on the risk of the induction procedure. If not, the risk of induction would be higher than indicated in the AMA report. (Tr. 180:14-181:18.)

abortion procedures performed at 13 weeks' gestation and beyond, the AMA report cited statistics from the "best available national data on complications" collected during the 1970s by the Joint Program for the Study of Abortion, sponsored by the Population Council and the CDC. According to the report, the complication rate associated with vacuum aspiration was 2 per 1000 procedures; D & E had a complication rate of 7 per 1000 procedures; labor induced by saline or prostaglandin injection had rates of 21 and 25 per 1000 procedures respectively; and abortion methods involving major surgery had the highest rate of complications. (Ex. 7, at 10:20-26; 10:43-48; 11:30-31.)

79. Forcing a woman to wait until post-20-weeks' gestation so that Carhart may be able to achieve fetal demise prior to performing an abortion drastically increases the risk of complications. According to the studies with which Carhart is familiar, abortion at the earliest stage is 35 times safer than childbirth as far as complications are concerned. By the 20th week, the risk of complications from abortion approximately equals that of childbirth. (Tr. 135:18-136:9, Carhart Test.; Tr. 59:9-10, Henshaw Test.)

80. The complication rate from abortion increases by about 20 percent for each week of gestation past eight weeks. (Tr. 59:11-14, Henshaw Test.)

81. According to his analysis of data from the Nebraska Department of Health and Human Services, Dr. Henshaw opined that D & E is the prime method of abortion performed in Nebraska after the first trimester of pregnancy. Of the 5,214 reported abortions in Nebraska

in 1996, 5,161 were performed by suction curettage, the prime method for first trimester abortions; 550 were performed by "sharp curettage" which were "most likely D & E's"; no inductions were performed; and 49 abortions recorded as "other" were most likely drug-induced abortions prior to eight weeks' gestation. (Tr. 49:4-50:9; Ex. 9, Neb. 1996 Statistical Report of Abortions at 2, 4 (tbls. 1, 5).)

82. Nationwide approximately 86 percent of abortions past 15 weeks are performed by curettage, or D & E, while induction is performed in less than 10 percent of abortions past 15 weeks. (Tr. 50:15-51:9; Ex. 17, 1992 Abortion Surveillance Report, tbl. 16, reported legal abortions, by weeks of gestation and type of procedure – U.S., 1992 (Centers for Disease Control 1992).)

83. The number of curettage, or D & E, procedures reported in Nebraska and across the nation also includes the intact D & E or D & X,[22] so there is "no way to quantify how many of the D & X abortions are done based on the statistics collected by the State [of Nebraska] or the CDC." (Tr. 52:1-5, Henshaw Test.)

84. According to a study by Dr. Henshaw, only 25 abortions, or .4 percent of the total, were performed in Nebraska hospitals in 1992, and only three Nebraska hospitals reported performing abortions that year. Two of

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[22] Carhart testified that he records intact D & E or D & X procedures under "Dilation and evacuation (D & E)," (Ex. 11), or "suction curettage," (Ex. 12), on various Nebraska abortion-reporting forms. (Tr. 128:1-129:24.)

the three indicated a referral must be made by an attending physician, and one hospital did not answer the question, leading Dr. Henshaw to conclude that a woman cannot arrange an abortion directly with a Nebraska hospital. Although no such information was requested in the 1992 survey, one Nebraska hospital reported that abortions were permitted only for therapeutic reasons. (Tr. 55:10-56:19.)

I. Interpretation of LB 23

85. *Dr. Carhart:* Dr. Carhart does not understand the meaning of "substantial portion," as used in the definition of "partial-birth abortion" in LB 23. "I think it could mean any identifiable part of the fetus. I think it could mean the umbilical cord. I think it could mean an extremity, I think it could mean a portion of an extremity, a foot, a toe, a hand, a finger. I think it could mean a portion of the skull, if it's a face-first presentation, where the forehead protrudes from the cervical os before anything else come out." (Tr. 89:7-90:5.) "Living unborn child," as used in the same definition, has no medical meaning in Dr. Carhart's opinion, as compared to a living fetus, which is a fetus that has a heartbeat and is undergoing normal genetic or embryonic development. (Tr. 90:6-24.)

86. *Dr. Hodgson:* Dr. Hodgson believes that LB 23, as written, applies to 95 percent of all abortion procedures because during these procedures, portions of a fetus can enter the vagina spontaneously when the fetus is still living, and with all abortions, a physician begins the procedure with a live fetus with the intent to end the procedure with a dead fetus, and at what point that death

occurs is "extremely variable." (Tr. 216:17-219:7.) Dr. Hodgson thinks heartbeat is the best measure of a "living" fetus currently available. (Tr. 219:16-220:3.)

87. *Dr. Stubblefield:* The term "partial-birth abortion," as used in the Nebraska LB 23, is not a term Dr. Stubblefield has encountered in medical textbooks or articles. The phrase "partially delivers vaginally," as it appears in the definition of "partial-birth abortion" in LB 23, "are words that a nonmedical person has made up. I presume they mean pull a piece of the fetus down into the vagina and out of the vagina." (Tr.2d 54:16-55:8.) Dr. Stubblefield interpreted the phrase "delivering into the vagina a living unborn child" in the definition of "partial-birth abortion" to mean to "pull the fetus [from within the uterus and through the cervix and] down into the vagina," but not necessarily outside of the woman's body. (Tr.2d 55:13-22.) Dr. Stubblefield testified that the meaning of "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof" in LB 23 was "[s]ubject to opinion" because "[t]here is no legal or medical definition of what constitutes a substantial portion of an unborn child." (Tr.2d 55:23-56:5.) Dr. Stubblefield testified that if "substantial portion" meant "more than a little bit of the fetus," LB 23 "would be precluding most surgical abortions, making it illegal." (Tr.2d 62:5-12.)

With reference to the language in LB 23 that defines "partial-birth abortion" as being "for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child," Dr. Stubblefield stated that physicians

know that "[a]ll of the surgical abortion procedures, vacuum curettage, all variations of a D & E" will kill unborn children. (Tr.2d 56:6-15.) As stated above, Dr. Stubblefield opined that the "only way . . . to avoid" delivering into the vagina a "living unborn child, or a substantial portion thereof," as stated in LB 23, is either to (1) perform a "significantly riskier" abdominal operation, such as hysterotomy or hysterectomy, so that "nothing is delivered into the vagina" or (2) cause fetal demise prior to beginning any abortion procedure in every case. (Tr.2d 56:16-23; 57:3-8.)

88. *Dr. Riegel:* "Substantial portion," as used in LB 23, means "probably over 50% of the size [of the fetus] probably would be what that would mean. It's a vague term," according to Dr. Riegel. (Tr. 315:7-25.) Dr. Riegel does not think LB 23 contemplates removal of a fetal leg from a woman's uterus while the remainder of the fetus is still living inside the uterus; instead, he thinks the procedure addressed by LB 23 is delivery of 50 to 75 percent of the fetus – or up to the fetus' chest or head – "and then the life of the baby is specifically ended at that point before the head comes out. . . . " (Tr. 316:8-23; 318:16-20.)

89. *Dr. Boehm:* As he reads the language of LB 23, Dr. Boehm believes LB 23 prohibits the intact D & E. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 53:15-18.) Dr. Boehm testified that he understands the definition of "partial-birth abortion" as used in LB 23, and he believes it includes the procedure as defined by ACOG; that is, intentional dilation of the cervix, conversion of the fetus to a breech, extraction of the fetus to the head, and evacuation of the intracranial contents. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 25:8-11; Ex. 32, Dep. of Dr.

Boehm, at 31:2-18.) Dr. Boehm concedes that "some people might consider a hand or a leg to be a substantial portion" within the meaning of LB 23, but he interprets that phase to mean "more than a hand or a leg." (Ex. 27, Videotaped Dep. of Dr. Boehm, at 61:3-11.)

> I think you'd have to bring in a reasonably large portion of the fetus through the birth canal. And I'm not sure that I can define that, but I don't think anyone has or could. So I think that's where some people have been concerned.
>
> I feel substantial portion means a significant portion of the fetus. And while I could say greater than half of the body, that would be my own personal view and not necessarily the view of someone who wants to prosecute this letter of the law.

(Ex. 32, Dep. of Dr. Boehm, at 33:17-34:1.)

J. Fear of Prosecution

90. Carhart fears prosecution under LB 23 because the Nebraska Attorney General's Office and the State Department of Health are both aware of, and have investigated, his performance of abortions in the past. (Tr. 136:10-137:22; Ex. 20, Letter from Att'y Gen.'s Office to Carhart of 11/22/95; Ex. 21, Letter from State Dep't of Health investigator to Carhart att'y of 10/9/96.)[23]

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[23] These exhibits were received to the extent they are relevant to Carhart's fear of prosecution. (Tr. 6:18-7:23; 9:19-21.)

II. CONCLUSIONS OF LAW

Before addressing the merits of this case, I pause to note two things. First, I have previously found that the court has subject matter jurisdiction; that this case is ripe for decision; and that Carhart has standing for himself and for his patients. *Carhart I*, 972 F.Supp. at 520-21. No one has challenged these decisions. In any event, I again decide that the court has subject matter jurisdiction; that this case is ripe for decision; and that Carhart has standing for himself and for his patients. *Id.* Second, the facts and conclusions expressed in *Carhart I* have not been altered by the additional evidence or the passage of time. For the sake of convenience, I simply incorporate those facts and conclusions into this opinion as if I set them forth verbatim. With that said, I now address the merits of this case.

A. The Court Declines to Review the Facial Validity of the Law.

Contrary to the [sic] Dr. Carhart's earlier position, *Carhart I*, 972 F.Supp. at 522-23, he now challenges Nebraska's law as it is applied and on its face. The defendants do not object to this change in position. As a matter of fact, they also urge me in their brief to reach the question of whether the law is facially valid.

A law may be challenged as unconstitutional in two ways. The law may be challenged "as applied" and "facially." *See, e.g., Ada v. Guam Soc. of Obstetricians & Gynecologists*, 506 U.S. 1011, 1012-13, 113 S.Ct. 633, 121 L.Ed.2d 564 (1992) (Scalia, J. dissenting); *WMPC II*, 130

F.3d at 193-94; Michael C. Dorf, *Facial Challenges to State and Federal Statutes*, 46 Stan. L.Rev. 235 (1994). If the law is judged unconstitutional on facts peculiar to the plaintiff, then the law is unconstitutional "as applied." *Ada*, 506 U.S. at 1013, 113 S.Ct. 633 (Scalia, J. dissenting) If, on the other hand, the law is found unconstitutional regardless of how it might be applied to a particular plaintiff then the law is said to be facially unconstitutional. *Id.* The difference between the two challenges is this: if a law is facially invalid it cannot be enforced against anyone, but if a law is unconstitutional "as applied," while it cannot be enforced against the plaintiff (or others like him), the law is otherwise generally enforceable. *Id.*

I am not persuaded that it is proper to reach the question of whether Nebraska's partial-birth abortion law is facially valid. My reasons for this decision are set forth below.

First, there is currently a dispute among members of the Supreme Court regarding whether a successful "facial" challenge to an abortion law requires proof that in "no set of circumstances" is the law valid or whether it is enough to show the law is invalid "in a large fraction of cases." *Compare, e.g., Janklow v. Planned Parenthood, Sioux Falls Clinic*, 517 U.S. 1174, 1583, 116 S.Ct. 1582, 134 L.Ed.2d 679 (1996) (Justice Stevens) *with Janklow v. Planned Parenthood, Sioux Falls Clinic*, 517 U.S. at 1584, 116 S.Ct. 1582 (Justice Scalia) (commenting upon denial of certiorari). The defendants argue that this dispute has caused our circuit court to take positions that are contradictory and they urge me to apply the more restrictive of the two tests. *Compare Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1458 (8th Cir.1995) (applying

"in a large fraction of cases" test), *cert. denied*, 517 U.S. 1174, 116 S.Ct. 1582, 134 L.Ed.2d 679 (1996), *with Fargo Women's Health Organization v. Schafer*, 18 F.3d 526, 529 (8th Cir.1994) (applying both tests but stating "the [stricter] standard remains the law.' ") If I can avoid reaching an issue that is apparently subject to debate even among the Justices, it seems prudent to do so.

Second, and more importantly, the Supreme Court has suggested that a lower court faced with an "as applied" and a "facial" challenge can, and probably should, avoid deciding the "facial" challenge if the law "as applied" is unconstitutional and the decision on that point resolves the controversy between the litigants. *See, e.g., Renne v. Geary*, 501 U.S. 312, 323-24, 111 S.Ct. 2331, 115 L.Ed.2d 288 (1991) (suggesting that resolution of the "as applied" challenge first was the "better course" because that procedure avoided " 'gratuitous wholesale attacks upon state and federal laws.' ") (quoting *Board of Trustees of State University of N.Y. v. Fox*, 492 U.S. 469, 484-85, 109 S.Ct. 3028, 106 L.Ed.2d 388 (1989)).[24]

Since I will invalidate the Nebraska "partial birth abortion" statute as applied to Dr. Carhart and his patients (and similarly situated persons), numerous prudential considerations counsel against reaching the

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[24] Dr. Carhart concedes that the court may avoid the "facial" challenge if the court finds the law invalid "as applied" to him. "This dual request by the plaintiff does not require the Court to consider the requests in any particular order, nor does it require the Court to reach both challenges if it finds for the plaintiff on one challenge." Plt's Post-Trial Br. at 1 n.1. (Citation omitted.)

"facial" challenge. For example, due to the absence of specific evidence about other doctors and patients, a facial challenge forces me to guess about a wide variety of fact patterns that might occur in various unknown surgical suites involving various unknown doctors and patients with various unknown motives and conditions. Moreover, since Carhart is the only doctor in Nebraska who performs these types of late-term abortions, but he does not perform abortions after viability, one wonders why it is advisable to reach the facial question under any circumstance. In any event, the Supreme Court has suggested that if a judge is not required to guess about such things, the judge ought to refrain from doing so, *Renne*, 501 U.S. at 323-24, 111 S.Ct. 2331, and that is what I will do.

In summary, because I find Nebraska's law unconstitutional as applied to Dr. Carhart and his patients, it is unnecessary to decide whether Nebraska's law is facially invalid. I therefore decline to decide the facial invalidity question, and I express no opinion whatever on the matter.

B. "As Applied" to Dr. Carhart, Nebraska's Law is Unconstitutional.

Dr. Carhart essentially makes three arguments.[25] Each one has merit.

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[25] Before arguing that the law is invalid because it is an "undue burden," the plaintiff asserts that he need not show an "undue burden." Essentially, the plaintiff argues that once a woman has chosen to have an abortion the state cannot constitutionally dictate the choice of method. I find it unnecessary to reach this argument.

First, the D & X procedure that Dr. Carhart performs is the safest procedure to use when he uses it. Therefore, the law imposes an undue burden on the doctor and his patients because the law forces an unconstitutional trade-off. In other words, Nebraska's law forces women and their doctors to unnecessarily use an appreciably riskier procedure to promote nonviable fetal well-being.

Second, Nebraska's "partial-birth" abortion law bans the D & E procedure because when a fetus is dismembered the dismemberment routinely involves an intentional and deliberate vaginal delivery of a "substantial portion" of the intact fetus in order to accomplish dismemberment. Since the D & E procedure is the most frequently performed abortion procedure and is universally regarded as being safer than any other procedure (save for the intact D & E or D & X which is a variant of the standard D & E) the law imposes an undue burden; that is, the law forces an unconstitutional trade-off by requiring women and their doctors to unnecessarily accept appreciably greater risk to promote nonviable fetal well-being.

Third, the law is void because the words "substantial portion" are vague. In other words, a doctor of reasonable competence cannot know from a plain reading of the words what "substantial portion" means, and, as a result, a reasonable doctor and patient cannot be expected to conform his or her conduct to Nebraska's law. Moreover, the law is ripe for arbitrary enforcement.

Before discussing these arguments in detail, it is necessary to be precise about what Carhart does and does not do. The following summary is therefore presented:

1. Carhart does not intentionally perform abortions on viable fetuses.

2. Between the 16th and 20th week, Carhart performs both the D & E procedure and a variation of the D & X[26] (sometimes called intact D & E).

3. The D & E procedure used by Carhart involves the following: (a) inserting an instrument into the uterus; (b) grasping a part of the living fetus, such as a limb; (c) pulling the fetal part through the cervix; and (d) shearing the part from the body by means of traction where the end of the cervix (cervical os) is the leverage point.

4. The D & X procedure used by Carhart involves the following: (a) if the fetus is in the footling breech position (feet first), inserting an instrument into the uterus and grasping the living fetus; (b) pulling the intact living fetus, except the head, through the cervix from the uterus into the vaginal cavity; (c) draining or crushing the fetal skull which is too large to pass through the cervix unless the size of the skull is reduced.[27]

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[26] "Partial-birth abortions" are "known medically as intact dilatation and extraction, or D & X." Julie Rovner, *US Senate Rejects Post-Viability Abortion Ban*, 349 THE LANCET 9064 (May 24, 1997). According to *The Lancet*, "[T]he vast majority of D & X abortions are performed either before the fetus is viable or when viability is extremely doubtful." *Id. The Lancet* is "the United Kingdom's leading medical journal." *LaMontagne v. E.I. Du Pont De Nemours & Co.*, 41 F.3d 846, 850 (2d Cir.1994).

[27] The defendants object to my description of the procedure. While they do not suggest that I have been inaccurate, they suggest that I have not been graphic enough. For example, they would like me to state "that the procedure literally sucks the brains out of a living partially born child." Post-Trial Br. of Defs. at 11 n.2. It would not be helpful to respond to this objection and other provocative statements contained in defendants' otherwise well-written brief.

5. Carhart's D & X procedure is similar to Dr. Haskell's procedure except for two variations. Unlike Haskell, Carhart does not intentionally convert the fetus to a footling breech; that is, he takes the fetus as he finds it. If the fetus presents feet first, Carhart will do a D & X. If, on the other hand, the fetus does not present feet first, Carhart will do a D & E.[28] Moreover, Carhart will do the D & X procedure between the 16th week and the 20th week unlike Dr. Haskell who uses the procedure between the 20th and 24th week.

6. Carhart performs about 190 abortions a year between the 16th week and the 20th week. In each of these 190 cases Carhart always tries to do the D & X procedure because he believes it is obviously safer. However, because the fetus does not always present feet first and Carhart will not try to convert the fetus to a footling breech, Carhart is able to perform the D & X procedure 10 to 20 times a year. If he cannot perform the D & X, Carhart will do a D & E.

7. After 20 weeks, Carhart induces fetal death by injection unless the woman suffers from a seizure disorder or heart disease or is taking medication that contraindicates use of injection.

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[28] Other doctors use this variation as well. *WMPC I*, 911 F.Supp. at 1067 n. 20 (Dr. Doe Number Two).

With the foregoing summary in mind, I now turn to the arguments advanced by Carhart and the defendants.

1. Because the Law Bans the D & X Procedure, it Imposes an "Undue Burden" on Dr. Carhart and his Patients; that is, in Dr. Carhart's Hands the D & X Procedure is the Safest Procedure in Certain Circumstances.

(a)

The defendants have conceded that Nebraska's law would prohibit Carhart from using his version of the D & X procedure. Specifically, the defendants have stated that 10 to 20 D & X abortions performed by Carhart in 1996 would have been prohibited by Nebraska law. *Carhart I*, 972 F.Supp. at 520. As a consequence, I must determine whether that prohibition is constitutional.

An abortion law is invalid if it places an "undue burden" in "the path of a woman seeking an abortion before the fetus attains viability." *Planned Parenthood v. Casey*, 505 U.S. 833, 878, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992). An "undue burden" can arise in two circumstances; that is, one examines the "purpose" and "effect" of the law. If the legislature intended to place a substantial obstacle in the path of a woman seeking an abortion, then an undue burden exists. *Id.* at 877, 112 S.Ct. 2791. If the effect of the law is to place a substantial obstacle in the path of a woman seeking an abortion, then an "undue burden" has been proven. *Id.*

It is beyond dispute that "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion

impose an undue burden." *Id.* at 878, 112 S.Ct. 2791. The Supreme Court and lower federal courts have consistently held that abortion regulations that impose medically unnecessary health risks on women are invalid. *See, e.g., Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 768, 106 S.Ct. 2169, 90 L.Ed.2d 779 (1986) (state law not susceptible to construction that did not " 'require the mother to bear an increased medical risk in order to save her viable fetus' " was unconstitutional) (citation omitted)[29]; *Colautti v. Franklin*, 439 U.S. 379, 400, 99 S.Ct. 675, 58 L.Ed.2d 596 (1979) (state law requiring a doctor to use the technique that provided the best opportunity for the viable fetus to be aborted alive was unconstitutional because it was uncertain whether the law permitted "the physician to consider his duty to the patient to be paramount to his duty to the fetus"); *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52, 79, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976) (state law that "forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed" was unconstitutional); *Jane L. v. Bangerter*, 102 F.3d 1112, 1118 n. 7 (10th Cir.1996), *cert. denied sub nom. Leavitt v. Jane L.*, ___ U.S. ___, 117 S.Ct. 2453, 138 L.Ed.2d 211 (1997) (Utah's choice of method statute was unconstitutional because " 'by requiring a woman to suffer "grave damage" to her health before her liberty interests predominate, the Utah legislature violated those portions of *Roe* and *Thornburgh* . . . that *Casey* reaffirmed

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[29] *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 106 S.Ct. 2169, 90 L.Ed.2d 779 (1986), *overruled in part on other grounds in Casey*, 505 U.S. at 870, 882, 112 S.Ct. 2791 (O'Connor, Kennedy, & Souter, JJ.).

and unconstitutionally devalued a woman's privacy rights.' ") (quoting *Thornburgh*, 476 U.S. at 769, 106 S.Ct. 2169 and *Jane L. v. Bangerter (IV)*, 61 F.3d 1493, 1502-1504 (10th Cir.1995), *rev'd in part on other grounds sub nom. Leavitt v. Jane L.*, 518 U.S. 137, 116 S.Ct. 2068, 135 L.Ed.2d 443 (1996) (per curiam)); *WMPC I*, 911 F.Supp. at 1070 (D & X procedure "appears to pose less risk to maternal health than any other alternative"; therefore, the ban had the "effect of placing a substantial obstacle in the path of women seeking pre-viability abortions" and was "an undue burden and thus unconstitutional under Casey ").

I have previously found that Nebraska's ban on the variant of the D & X procedure performed by Carhart has the "effect" of subjecting his patients to an appreciably greater risk of injury or death than would be the case if these women could rely upon Dr. Carhart to do his variant of the banned procedure when medically advisable. *Carhart I*, 972 F.Supp. at 523-28. The result is an undue burden under *Casey*.

I have also previously set forth in detail why it has been proven that Nebraska's law endangers women by prohibiting Dr. Carhart, a well-trained former head of surgery at a large Air Force hospital, from performing the D & X procedure when medically advisable. Without reciting again each particular, the following summary is provided:

> 1. Statistically, the D & X procedure is at least as safe as the D & E procedure and appreciably safer than all other forms of abortion. *Carhart I*, 972 F.Supp. at 525.
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> 2. The variant of the D & X procedure used by Carhart is appreciably safer than the D & E procedure, for among other reasons, because (a) it reduces instrumentation in the uterus that can cause damage to the uterus and cervix; (b) it reduces uterine or cervical perforation from bony fragments; (c) it prevents disseminated intravascular coagulopathy (DIC) and amniotic fluid embolus (among the most common causes of maternal mortality and complications); (d) it reduces the likelihood of retained fetal parts (a "horrible complication"); (e) it reduces the risk of "free floating head," an uncommon but significant complication; (f) because the D & X is less time consuming than dismembering the fetus, the woman has less operative time, which means less risk of hemorrhage, less total bleeding and less risk of infection when the procedure is used. *Id.* at 525-27.

3. Inducing fetal death by injection before the 20th week of pregnancy carries with it appreciable maternal health risks, no maternal benefits, and is not always possible. Consequently, if Carhart has to ensure fetal death by injection before the 20th week in order to do a D & X procedure, he endangers his patients for no reason related to the health or life of the patients. *Id.* at 527-28.

4. There is no maternal health benefit in forcing women to wait until after the 20th week so that the fetus can be killed by injection, and there is appreciable risk to maternal health in doing so. Consequently, to the extent the statute requires such a waiting period so that the fetus is dead prior to the commencement of the D & X procedure, Carhart is forced to endanger his patients for no reason related to the health or life of the patients. *Id.* at 528.

5. Cutting the umbilical cord and waiting for the fetus to die before completing the D & X procedure carries appreciable maternal risks, no maternal benefits, and is not always possible. Consequently, to the extent the statute requires such a procedure as a condition for performance of the D & X procedure, Carhart is forced to endanger his patients for no reason related to the health or life of the patients. *Id.*

(b)

Nothing has been presented at the trial on the merits which causes me to deviate from my previous decision that Nebraska's law endangers women by prohibiting Dr. Carhart from performing his version of the D & X procedure. As a result, I hold that the law is an "undue burden" within the meaning of Casey because it has the "effect" of subjecting Dr. Carhart's patients to an appreciably greater risk of injury or death than would be the case if these women could rely upon Dr. Carhart to do his variant of the banned procedure when medically advisable prior to the fetus becoming viable.[30]

Through their able counsel, the defendants advance numerous arguments to support their view that the ban on the D & X procedure does not impose such an undue burden.[31] Only three of those arguments, however, merit a direct response. The defendants continue to argue that the D & X procedure is not recognized by the medical

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[30] Because of this holding, it is unnecessary to decide whether the legislature's purpose in enacting the law was to impose an undue burden.

[31] The main initial brief of the defendants is 114 pages long.

profession, and I should not judge the question in any event. Moreover, the defendants argue that the D & X procedure is not needed since there are other safe alternatives. Finally, the defendants urge the court to hold that the State of Nebraska may constitutionally require women to accept a small increased risk to maternal health or life in order to promote the well-being of a nonviable, yet living, fetus.

(i)

As if repeating the argument would make it so, the defendants continue to assert that the D & X procedure is not recognized by the medical profession. The evidence is quite to the contrary.

For example, Dr. Phillip Stubblefield, Chairman of the Department of Obstetrics and Gynecology at the Boston University School of Medicine, as well as Chief of Obstetrics and Gynecology at the Boston Medical Center, testified that he has added a description of the D & X procedure to a chapter he regularly writes and revises for *Dr. Nichols's Textbook of Gynecologic Surgery*, and he plans to teach the procedure at the teaching hospital with which he is currently affiliated. (Tr.2d 74:6-11; 80:11-81:12.) Dr. Stubblefield views the D & X technique as a safe method of abortion and he plans to use it himself. (Tr.2d 44:3-10.)

Likewise, Dr. Jane Hodgson, founding fellow of the American College of Obstetrics and Gynecology, past president of the Minnesota Ob/Gyn Society, and author of 50 to 100 published articles on abortion, (Tr. 196:16-24; 197:11-13; Ex. 14, Hodgson *Curriculum Vitae*, at 2) testified

that she believes the procedure is a technological advance that has received favorable reports from those who are performing the procedure. (Tr. 212:8-22.) Dr. Hodgson believes the D & X procedure is "an advance in technology" because by removing the fetus intact there is "less instrument manipulation," which means, "of course, the higher your safety." (Tr. 212:4-22.)

Moreover, even a cursory survey of other cases and the literature establishes that the D & X procedure, while certainly new, is well accepted by many highly regarded persons in the medical profession who specialize in abortion related medicine. *See, e.g., Evans v. Kelley*, 977 F.Supp. 1283, 1296 (E.D.Mich.1997) (stating that six doctors, all of them board certified, including a court appointed expert[32] and an expert for the State of Michigan, "all agree" that the D & X procedures "reduce risks associated with conventional D & Es"); *WMPC I*, 911 F.Supp. at 1069 (reciting the testimony of Dr. George Goler, Ohio section chief of the American College of Obstetricians and Gynecologists, who testified that he "views [the D & X procedure] as an improvement over the traditional D & E procedure"); Ann MacLean Massie, *So-called "Partial Birth Abortion" Bans: Bad Medicine? Maybe. Bad Law? Definitely!*, 59 U. Pitt. L.Rev. 301, 371 (1998) (summarizing medical testimony given to the Senate on the federal "partial-birth" abortion ban; stating that the "most objective and expert testimony came from Dr. Warren Hern"; observing that: "Dr. Hern told the Senate Committee: [']The possible advantages of Intact D & E procedure include a reduction

[32] Both the plaintiff and the defendants declined the court's invitation to appoint a medical expert for the court in this case.

of the risk of perforation of the uterus. Since most women seeking abortions are young women who hope to reproduce in the future, having a safe abortion technique for late abortion is of paramount importance, aside from the prevention of complications. Another advantage of the Intact D & E is that it eliminates the risk of embolism of cerebral tissue into the woman's blood stream. This catastrophe can be almost immediately fatal.[']") (hereafter *"Partial-Birth Abortion" Bans*).[33]

The defendants decry the lack of "studies." To the defendants, the lack of these studies show that the D & X procedure is not accepted by the medical profession. This criticism is both misleading and inaccurate.

Initially, as Dr. Stubblefield pointed out, many accepted surgical techniques (open heart surgery among them) are commonly developed without statistical studies.[34] For example, Dr. Boehm, the defendants' expert, admitted that he decided to use the prostaglandin form of induction rather than saline form of induction based upon his clinical experience but without such studies. (Ex. 27, Videotaped Dep. of Dr. Boehm, at 73:9-74:17.) Moreover, since the D & X is a less invasive

[33] Dr. Hern also told Congress that although he had not yet used the D & X procedures, he believed that the procedures sought to be banned by the proposed federal "partial-birth abortion" law "are followed by attending physicians throughout the nation when the safety of the woman having the abortion is at issue." *Id.* at 336 (footnote omitted). Dr. Hern is the author of "the principal medical textbook on abortion procedures, and a well-known authority on the subject." *Id.* at 335 & n. 170.

[34] Food and drug cases are therefore irrelevant.

variant of the D & E, and the D & E has been found to be statistically the safest procedure, one can reasonably infer that the D & X is at least as safe as the D & E. Finally, one of the pioneers of the D & X procedure, Dr. Haskell, in fact did a comparative, although not statistically controlled, study. He compared 1000 D & X procedures he performed against 1000 D & E procedures he also performed. Dr. Haskell found the D & X procedure to have fewer complications than the D & E procedure. *WMPC I*, 911 F.Supp. at 1069.

To be sure, there are those doctors, like defendants' expert Dr. Boehm, who profess unfamiliarity with the D & X procedure[35] or who dislike it for political reasons.[36] Nevertheless, it is factually erroneous to argue that the D & X procedure is not recognized by mainstream medical professionals. On the contrary, the procedure is well within accepted medical practice.

The defendants, in a related argument, suggest that this court oversteps its authority in judging the efficacy

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[35] Unlike Dr. Stubblefield, a teacher and user of the D & E procedure, Dr. Boehm has not performed a standard D & E procedure for 10 to 15 years. He does not teach the procedure either. As a consequence, it is not surprising that Dr. Boehm did not appreciate advances in the D & E technique, such as the D & X procedure.

[36] For example, Dr. Boehm, who generally supports abortion rights, testified that he opposed the "D & X" procedure for what appeared to be tactical reasons; that is, "such a procedure should be banned so as to comfort the general public in this country that abortions are not in the hands of callous extremists." (Ex. 27, Videotaped Dep. of Dr. Boehm, at 66:23-68; Ex. 25 at 2.) This case is not, however, about what is the best political tactic to advance a particular viewpoint.

of the D & X procedure when the Nebraska legislature has come to a contrary conclusion. The defendants suggest that I have no business second guessing the legislature on whether the D & X procedure is an appropriate and necessary surgical technique. I reject this argument.

The Supreme Court has commanded the lower federal courts to enforce the following constitutional principle: "Unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right [to seek an abortion of a nonviable fetus]" *Casey*, 505 U.S. at 877, 112 S.Ct. 2791. This court cannot fulfill the mandate of the Supreme Court without deciding whether Nebraska's law presents such an undue burden. To make that decision, the court must evaluate the procedure and the reasons for or against use of the procedure. The Supreme Court has not hesitated to evaluate and invalidate state laws that ban specific abortion methods. *See, e.g., Danforth*, 428 U.S. at 75-79, 96 S.Ct. 2831 (striking down prohibition against saline amniocentesis after the first 12 weeks of pregnancy).

As a consequence, there is nothing inappropriate about the court's review of Nebraska's legislative declarations. Therefore, because the D & X procedure has been shown by medical evidence to be the safest procedure used by mainstream medical professionals like Dr. Carhart in certain circumstances, the court reiterates its view

that Nebraska's wholesale ban of the procedure prior to viability is an "undue burden" under *Casey*.[37]

(ii)

The defendants argue that no undue burden is presented by the ban of the D & X procedure because other *equally* safe abortions procedures are still available. When the D & X procedure is used by Carhart, I find and conclude, as I have before, *Carhart I*, 972 F.Supp. at 529-30, that there are no *equally* safe alternatives.

First, the statistical evidence shows without a doubt that the D & E, and by inference its variant the D & X, is the safest of all other abortion procedures used during the gestational age during which Carhart performs the D & X. *Carhart I*, 972 F.Supp. at 525. For example, compared to induction abortions, the D & E is nearly twice as safe as the next safest procedure. *Id.* (citing AMA report, Ex. 7, at 10, tbl. 4 (between 13 and 21 weeks) (3.7 deaths per 100,000 for D & E's vs. 7.1 deaths per 100,000 for inductions)).[38]

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[37] It is worth noting again that the defendants do not argue that the "medical exception" provision of LB 23 would permit Carhart to perform the D & X procedure if necessary to preserve the life or health of the patient. *Carhart I*, 972 F.Supp. at 529. The medical exception would not apply to Carhart's patients because risks to maternal health are not considered and relative surgical risks are not considered either. *Id.*

[38] I also note that even if the induction method were equally safe (and it is not) induction requires a patient to undergo labor in a hospital, with greater pain and economic cost, and induction procedures are not generally available to most women in Nebraska for elective abortions. As a consequence, the D & X ban would constitute an "undue burden" even if the induction procedure were as safe. *Id.* at 529 n. 37.

Second, the medical evidence shows that when Carhart uses the D & X it is safer than the standard D & E. In the 10 to 20 times a year when Carhart can do his version of the D & X, rather than the D & E, Carhart: reduces operating time, blood loss and risk of infection; reduces complications from bony fragments; reduces instrument-inflicted damage to the uterus and cervix; prevents the most common causes of maternal mortality (DIC and amniotic fluid embolus); and eliminates the possibility of "horrible complications" arising from retained fetal parts. *Id.* at 525-27. These substantial safety enhancements arising from use of the D & X are particularly evident because Carhart takes the fetus as he finds it. His version of the D & X thus requires a minimum of instrumentation in the uterus and cervix compared with the standard D & E.

In summary, the evidence is both clear and convincing that Carhart's D & X procedure is superior to, and safer than, the D & E and other abortion procedures used during the relevant gestational period in 10 to 20 cases a year that present to Dr. Carhart.[39] Other judges have

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[39] This is one reason why an "as applied" analysis, as opposed to a "facial" analysis, is preferable. In this case, rather than making generalizations about the relative safety of the D & X in all cases, the "as applied" analysis requires a focus on the particular procedures used by Dr. Carhart. Thus, the question is not whether the D & X is "always" safer. Rather, the question is whether it is safer in the 10 to 20 cases a year when Dr. Carhart uses his variant of the procedure. However, I also note that the difficulty in evaluating the safety of any surgical

come to similar conclusions. *See, e.g., Richmond Medical Center for Women v. Gilmore*, 11 F.Supp.2d 795, 827 n. 40 (E.D. Va.1998) (stating the "record here contains significant evidence that the D & X procedure is often far safer than other D & E procedures."); *Hope Clinic v. Ryan*, 995 F.Supp. 847, 852 (N.D.Ill., 1998) (reciting advantages of D & X; stating, among other things, that "the intact D & E reduces the risk of retained tissue and reduces the risk of uterine perforation and cervical laceration because the procedure requires less instrumentation in the uterus."); *Evans*, 977 F.Supp. 1283, 1296 (six board certified doctors "all agree" that the D & X procedures "reduce risks associated with conventional D & Es"); *WMPC I*, 911 F.Supp. at 1070 (D & X procedure "appears to pose less risk to maternal health than any other alternative"). *See also* Ann MacLean Massie, *"Partial Birth Abortion" Bans*, 59 U. Pitt. L.Rev. at 371 (stating that "the medical evidence . . . is inconclusive, [but] some relevant data suggest the possibility that D & X or intact D & E may actually represent an improvement over older late term techniques."; concluding that "the maternal health debate . . . fails to provide the factual foundation necessary for restricting a woman's right of access to this particular abortion method, if she and her physician should determine that it is the best procedure for preserving her physical, emotional, and psychological health"). *But see Planned Parenthood of Wisconsin v. Doyle*, 9 F.Supp.2d 1033 (W.D.Wis.1998) (concluding on affidavits that "[i]ntact

technique in specific settings is one reason why many doctors justifiably worry that legislatures may make life threatening mistakes when drafting sweeping legislation designed to deal with specific surgical techniques.

D & E's are no safer than conventional D & E's"; labeling the contrary finding in *Evans* as dicta; citing no cases in support of this finding) (preliminary injunction).[40]

(iii)

The defendants argue that even if the D & X procedure is safer, it is only marginally so. They argue that in order for a "burden" to be "undue" the burden must be "substantial"; in other words, the burden must present a "substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." *Casey*, 505 U.S. at 878, 112 S.Ct. 2791. They argue that Nebraska's law does not impose a "substantial obstacle." While I agree that the plaintiff must prove that the D & X ban poses a "substantial obstacle," I disagree with the factual premise of the defendants assertion; that is, the D & X ban is far from an insubstantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.

To promote nonviable fetal well-being, 10 to 20 women a year, who could not receive the best care possible from Dr. Carhart because of Nebraska's law, would be forced against their will to endure appreciably greater risks to their health and lives than are necessary. Among other things, they would suffer a larger than necessary risk of: (1) longer operating time; (2) greater blood loss and infection; (3) complications from bony fragments; (4)

[40] Despite this ruling, on June 25, 1998, the Seventh Circuit, with Judge Manion dissenting, enjoined enforcement of the Wisconsin law pending oral argument. *Planned Parenthood of Wisconsin v. Doyle*, 9 F.Supp.2d 1033 (W.D Wis.1998).

instrument-inflicted damage to the uterus and cervix, (5) exposure to the most common causes of maternal mortality (DIC and amniotic fluid embolus); (6) "horrible complications" arising from retained fetal parts. These are substantial obstacles within the meaning of *Casey*.

In summary, while it [sic] surely correct that the State of Nebraska has a profound interest in nonviable fetal life, it is beyond dispute that "a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability." *Casey*, 505 U.S. at 879, 112 S.Ct. 2791 (emphasis added). When a government compels 10 or 20 women to undergo a substantial risk of injury or death that could be avoided by the use of an accepted medical procedure in order to ensure the well-being of nonviable fetal life, an unconstitutional undue burden arises. The Supreme Court has made it plain that a government may not require a woman to sacrifice herself for a nonviable fetus and that is precisely what Nebraska's law requires.

2. Because the Law Prohibits Dr. Carhart from Vaginally Delivering a "Substantial Portion" of the Fetus for the Purpose of Performing an Abortion, the Law Imposes an "Undue Burden" on Dr. Carhart and his Patients; that is, Recognizing that the D & E is the Most Widely Used Procedure, Dr. Carhart cannot Perform the D & E Procedure and Still Comply with the "Partially Delivers Vaginally" and "Substantial Portion" Language of the Law.

Nebraska's ban has constitutional ramifications far beyond the 10 to 20 women a year who would be denied

the D & X procedure. The statute prohibits Dr. Carhart from using the standard D & E procedure. The ban therefore impacts every woman who seeks an abortion from Carhart between the 16th and 20th week; that is, the ban prohibits Carhart from employing the most widely used abortion technique for approximately 190 women each year. The ban therefore constitutes an undue burden.

(a)

The ban prohibits Dr. Carhart from performing a "partial-birth" abortion. LB 23 § 3(1). Because the term "partial-birth" abortion is unknown in medical circles, *see, e.g.*, Ann MacLean Massie, "Partial Birth Abortion" Bans, 59 U. Pitt. L.Rev. at 313, the Nebraska legislature, following proposed federal legislation, was required to define terms. In doing so, the legislature informed Dr. Carhart, and those like him, that a "partial-birth abortion" means an abortion "procedure in which the person performing the abortion *partially delivers vaginally*" the fetus. LB 23 § 2(9). (Emphasis added). Because "partially delivers vaginally" was not clear, the legislature enacted another definition; that is, "partially delivers vaginally" means "deliberately and intentionally delivering into the vagina a living unborn child, *or a substantial portion thereof*, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." *Id.* (Emphasis added.)

If the Nebraska legislature meant to ban only the D & X procedure, it did not accomplish its purpose. The words of the statute, fairly read, prohibit the D & E

procedure. Doctors routinely "deliberately and intentionally" deliver "vaginally" a "substantial portion"[41] of a living fetus in order to kill it when performing a D & E.

For the sake of clarity, I have attached to this opinion Ex. 34. This is a medical drawing of the pelvic anatomy of a female. The drawing makes it clear that a surgeon cannot perform a standard D & E in the usual case without "partially vaginally delivering" a substantial portion of a fetus. During, and as a deliberate and intentional part of, this process, the surgeon "rupture[s] the waters" and "usually something prolapses through the . . . cervical os [and] very often an extremity will." (Tr. 109:6-8.) In the case of a leg, the leg is then protruding into the vaginal cavity.

To dismember the leg, the limb must be shorn from the body and this occurs at the junction of the vaginal cavity and the cervical os. If the leg is not pulled against the end of the cervix there is no resistance and the leg cannot be torn from the body. Accordingly, the doctor "pull[s] down on it through the os" and the leg is sheared from the body as a result of the resistance (traction) between the instrument and the cervix. (Tr. 109:16-19.)

The evidence makes clear that the dismemberment occurs outside of the uterus and at least partially in the vaginal cavity after the extremity has been partially pulled through the cervix:

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[41] According to Dr. Stubblefield, these fetal parts routinely include legs or arms. (Tr.2d 31:16-17.)

Q When you are doing a D & E that involves dismemberment, where does the dismemberment occur; in other words, do you insert instruments into the uterus and dismember the fetus inside the uterus, or do you dismember it in some other way?

A Well, we insert one instrument inside the uterus, grab a portion of the fetus and pull it through the cervical os. The dismemberment occurs between the traction of . . . my instrument and the counter-traction of the internal os of the cervix. I suppose you could put two instruments in the uterus and try to dismember it. I think that would be very dangerous.

Q *So the dismemberment occurs after you pulled a part of the fetus through the cervix, is that correct?*

A *Exactly.*[42] Because you're using – The cervix has two strictures or two rings, the internal os and the external os, and you have – that's what's actually doing the dismembering. It's like who is pulling the cat's tail. If you are holding it and the cat's pulling it, something has to pull the other way. Otherwise, if you drag a string across the floor, you'll just keep dragging it. It's not until something grabs the other end that you are going to develop traction.

Q When we talked before or talked before about a D & E, that is not – where there is not intention to do it intact, do you, in that situation, dismember the fetus in utero first, then remove portions?

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[42] Dr. Stubblefield, an acknowledged expert on the use of the D & E, confirmed that the dismemberment did not occur in the uterus. (Tr.2d 30:23-25.)

A I don't think so. . . . I don't know of any way that one could go in and intentionally dismember the fetus in the uterus. If you grab an extremity and twist it, you can watch the whole fetus just twist. It takes something that restricts the motion of the fetus against what you're doing before you're going to get dismemberment.

Q When you pull out a piece of the fetus, let's say, an arm or a leg and remove that, at the time just prior to removal of the portion of the fetus, is the fetus alive?

A Very often, yes, sir.

(Tr. 116:2-117:13.)

This evidence is entirely consistent with testimony in other cases. *See, e.g., Richmond Medical Center,* 11 F.Supp.2d at 805 (stating that "in performing a D & E, a physician may intentionally 'deliver' a still-attached fetal limb into the vaginal canal before the limb is detached").

Dr. Stubblefield, an experienced practitioner and teacher of the D & E technique, testified that the effect of LB 23 was to ban D & E abortions. He stated that the "only way . . . to avoid" delivering into the vagina a "living unborn child, or a substantial portion thereof," as stated in LB 23, is to either (1) perform a "significantly riskier" abdominal operation, such as hysterotomy or hysterectomy, so that "nothing is delivered into the vagina" or (2) cause fetal demise prior to beginning any

abortion procedure in every case.[43] (Tr.2d 56:16-23; 57:3-8.) Dr. Stubblefield testified that the meaning of "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof" in LB 23 was "[s]ubject to opinion" because "[t]here is no legal or medical definition of what constitutes a substantial portion of an unborn child." (Tr.2d 55:23-56:5.) Dr. Stubblefield testified that if "substantial portion" meant "more than a little bit of the fetus," LB 23 "would be precluding most surgical abortions, making it illegal." (Tr.2d 62:5-12.)

In summary, when using the dismemberment D & E, the surgeon routinely dismembers a leg or arm from a nonviable, yet living, fetus. In any sensible and ordinary reading of the word, a leg or arm is "substantial." The physical act of dismemberment of this "substantial portion" of the intact fetus occurs partly in the vaginal cavity. The surgeon deliberately intends that all of these events occur in order to perform the D & E, a procedure the surgeon knows and deliberately intends will kill the nonviable living fetus.

Because Nebraska's law bans the D & E, the most widely used abortion procedure during the relevant gestational stage, an undue burden under *Casey* has been imposed upon Dr. Carhart and his patients who seek an abortion of a nonviable living fetus. The law is therefore unconstitutional. *See, e.g., WMPC II,* 130 F.3d at 200-01

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[43] As stated earlier, this alternative (causing fetal death by injection) has no maternal benefit, and carries with it real maternal risk, during the gestational stage that Carhart performs D & E and D & X abortions.

(Judge Kennedy, speaking for the Sixth Circuit, said: "Because the definition of the banned procedure includes the D & E procedure, the most common method of abortion[,]" the law "is an unconstitutional burden on a woman's right to choose to have an abortion.") (Ohio law provided that "No person shall perform a dilation and extraction procedure upon a pregnant woman" that involves the insertion of "a suction device into the skull of the fetus to remove the brain"); *Planned Parenthood of Greater Iowa v. Thomas Miller*, 1 F.Supp.2d 958, 963 (S.D.Iowa1998) (Iowa's "partial-birth abortion" law was so broad as to "encompass all pre-viability [abortion] procedures listed above [suction curettage and D & E] except for induction" and therefore the law likely violated *Casey*) (Iowa's law is nearly identical to Nebraska's; the law prohibits a doctor from "deliberately and intentionally delivering into the vagina a living fetus or substantial portion of a living fetus for the purpose of performing a procedure the person knows will kill the fetus, and then killing the fetus."); *Richmond Medical Center*, 11 F.Supp.2d at 825 (stating that the "D & E procedure likely is encompassed within the Act's ban"; finding an undue burden under *Casey* as a result) (Virginia's partial-birth abortion law is nearly identical to Nebraska's; under Virginia law a "partial-birth" abortion is defined as one "in which the person performing the abortion deliberately and intentionally delivers a living fetus or a substantial portion thereof into the vagina for the purpose of performing a procedure the person knows will kill the fetus, performs the procedure, kills the fetus and completes delivery."); *Hope Clinic*, 995 F.Supp. at 857 (finding

"the statute, as written, has the potential effect of banning the most common and safest abortion procedures" which the court previously described as the D & E and the intact D & E or D & X; the statute was therefore an undue burden under *Casey*) (law prohibited "an abortion in which the person performing the abortion partially vaginally delivers a living fetus or infant before killing the fetus or infant and completing the delivery."); *Planned Parenthood of Southern Arizona v. Woods*, 982 F.Supp. 1369, 1377-1379 (D.Ariz.1997) (noting that Arizona law could be construed to cover standard D & E procedures and that law could apply to "any part of alive intact fetus beyond the cervical os"; concluding that law was an unconstitutional burden under *Casey*) (Arizona law made it unlawful to "knowingly perform[ ] a partial birth abortion [that] kills a human fetus"); *Evans*, 977 F.Supp. at 1318 ("Michigan's 'partial-birth abortion' statute sweeps within its prohibition conventional D & Es" and "the law must be enjoined as unconstitutional under the undue burden analysis") (Michigan law used the phrase "partially vaginally delivers").[44]

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[44] I do not decide if the law reaches the suction curettage method. The parties have focused upon the D & E and D & X procedures. In passing, Dr. Carhart testified that when performing the suction curettage method, he does not intend to remove the fetus or parts from the fetus by "delivering it partially into the vagina . . . [b]ecause it goes through the tube through the vagina" outside the woman's body. (Tr. 156:7-16.) However, he also testified that he frequently is required to remove the tube to free it from obstructions and then the uterus expels the contents into the vaginal cavity. (Tr. 155:18-20.) Because the parties' evidence and written arguments only briefly touch on the question of whether the suction curettage

(b)

The defendants seek to avoid this ruling by trying to convince me that the law does not ban the D & E procedure. The defendants tacitly admit that if the statute banned the D & E procedure the law would be unconstitutional under current precedent. I am not persuaded by the defendants' arguments.

First, the defendants argue the Nebraska law is saved because the surgeon must "deliberately and intentionally" deliver into the vagina a substantial portion of the fetus for the purpose of performing a procedure that the person performing such procedure knows will kill the fetus and does kill the fetus. The defendants argue that unless the doctor deliberately intends to place a "substantial portion" of the fetus into the vagina for the purpose of performing the abortion the doctor has nothing to worry about.

The problem with the defendants' argument is that a surgeon performing a routine D & E deliberately intends to do exactly what the defendants admit is prohibited. In order to do a routine D & E, an intact limb usually enters the vaginal cavity after the "waters are ruptured," the surgeon deliberately intends for this to occur, and the

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method customarily results in "delivery[ ] into the vagina" within the meaning of the statute, I decline to reach the question. Should Nebraska, contrary to its position in this case, move to enforce the law against doctors performing the suction curettage method, I would quickly issue injunctive relief until that issue could be addressed with more care. *See, e.g., Planned Parenthood of Greater Iowa*, 1 F.Supp.2d at 963 (Iowa's law apparently included suction curettage).

surgeon deliberately intends to shear the "partially delivered" intact limb from the fetal body when that occurs. The dismemberment occurs, at least in significant part, in the vaginal cavity. As a result, the scienter provisions of the law do not serve to protect doctors who perform routine D & E procedures.[45] *See, e.g., Richmond Medical Center for Women*, 11 F.Supp.2d 795 (phrase "deliberately and intentionally" did not save Virginia's statute). Indeed, if the scienter provisions do anything, they serve to reinforce the broad criminal sweep of the law.

Second, the defendants argue that a surgeon need not worry because the Nebraska legislature did not intend to make criminal the D & E procedure. The problem, of course, with this argument is that the words of the statute, regardless of the legislature's intent, make the performance of the D & E a crime.

Moreover, a review of the legislative history refutes the assertion that the legislature did not intend to ban the D & E. If the legislative history reveals anything, it reveals that the legislature did not understand that the D & X (at least as performed by Carhart) varies in only small ways from the standard D & E technique. One simply cannot ascertain from the legislative history precisely what the legislature wanted to ban. We know the

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[45] This understanding of the mechanics of the D & E procedure distinguishes *Planned Parenthood of Wisconsin v. Doyle*, 9 F.Supp.2d 1033 (holding that a similar scienter provisions [sic] saved Wisconsin law). In that case, perhaps because the decision was based on affidavits rather than on a compete trial record, the judge had a different understanding of the mechanics of the standard D & E.

legislators wanted to ban "partial-birth" abortions, but that term is unknown in medical circles and it was poorly understood, if at all, by the legislature.

For example, Senator Chambers tried to ascertain whether the ban only applied to the delivery of the whole fetal body, excepting the head, into the vaginal cavity. He was told that such was not the case. Senator Chambers was told that even the delivery of a foot into the vaginal cavity would trip the criminal penalties of the statute. The exchange between Senator Chambers and Senator Maurstad, the introducer of the bill, follows:

> Senator Chambers: Senator Maurstad, you and Senator Dierks have talked about how perfect this language is, and Senator Dierks can be at least considered a quasi-scientist.[46] I'd call him a scientist. Show me in this bill where it says that a partial-birth abortion means that all of the child has been delivered except for the head. I don't see that in the language.
>
> Senator Maurstad: The language on page 3, and it's cited again later, Senator Chambers, indicates that "partial birth means," and then it goes on, "perform the abortion partially delivers vaginally a living unborn child."
>
> Senator Chambers: Where does it say, as you . . . are you willing to admit that the description you gave is not what's in the bill? You said, all is delivered except for the head. That's not in this bill, is it?

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[46] Senator Dierks is a veterinarian. Clerk of the Legislature, *Nebraska Blue Book* at 301 (1996-1997 ed.).

> Senator Maurstad: No, it says "partially delivered."
>
> Senator Chambers: And that could be a foot.
>
> Senator Maurstad: That could be a foot.

(Ex. 30, Floor Debate on LB 23 (May 12, 1997) at 6412.)

The day before the bill passed, Senator Chambers asked Senator Maurstad what "substantial portion" meant. Senator Maurstad responded: "I think substantial would indicate that *more than a little bit* has been delivered into the vagina. *I don't mean to be flippant.*" (*Id.* at 9231-32.) (Emphasis added.) Senator Chambers asked "how much is a little bit." (*Id.*) Senator Maurstad responded, "Enough that would allow for the procedure to end up with the killing of the unborn child." (*Id.*)

In summary, unless it is rewritten, Nebraska's law bans the D & E procedure. It is not the job of this court to rewrite legislation, particularly where, as here, no one could accurately ascertain what the legislature intended to do. *See, e.g., Evans*, 977 F.Supp. at 1303. The legislature elected to use nonmedical terms to describe surgical techniques and it must bear the consequences of that decision. Accordingly, Nebraska's law is unconstitutional as it bans the D & E procedure, and it thus imposes an undue burden on women seeking abortions of nonviable fetuses.

3. The Law is Void for Vagueness Because it Forces Dr. Carhart and His Patients to Guess About the Meaning of the Words "Substantial Portion."

While vaginal delivery of an arm or leg is a "substantial portion" of a fetal body, it is unclear what more the term "substantial portion" may mean.[47] Every doctor who testified, including the defense experts, stated that they did not understand the outer limits of the term or the term could be interpreted in vastly different ways by fair-minded people.

For example, Dr. Riegel succinctly stated that "substantial portion" is a "vague term." (Tr. 315:7-25). Unlike Senator Maurstad, who thought a foot would trigger the ban, Dr. Boehm thought "substantial portion" means "greater than half of the body." (Ex. 32, Dep. of Dr. Boehm, at 33:17-34:1.) Dr. Boehm was quick to admit, however, that his opinion "would by my own personal view and not necessarily the view of someone who wants to prosecute this letter of the law," *Id.*, and that, of course, is precisely the point.

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[47] The plaintiff also argues that other portions of the law, like "delivers" and "living," are vague. I need not reach these claims since resolution of the "substantial portion" issue, the one most hotly contested, ends the case. Moreover, these words take on particular meaning primarily when they are read with "substantial portion." Thus, it is difficult, if not impossible, to parse the meaning of these words when the term "substantial portion" is unconstitutionally vague. I note, however, that other courts have found these provisions unconstitutionally vague. *Richmond Medical Center*, 11 F.Supp.2d at 814-816; *Hope Clinic*, 995 F.Supp. at 854. I would likely do so as well.

A criminal law, especially one banning protected constitutional freedoms like abortion, that fails to give fair warning or that allows arbitrary prosecution is "void for vagueness." *See, e.g., WMPC II*, 130 F.3d at 197. Nebraska's partial birth abortion ban is the epitome of such a law; that is, the words "substantial portion" are so vague as to be meaningless to doctors, lay people and prosecutors alike. *See, e.g., Planned Parenthood of Greater Iowa*, 1 F.Supp.2d 958, 961-963 (granting preliminary injunction and concluding that Iowa's law, which is very similar to Nebraska's law, was likely unconstitutionally vague); *Richmond Medical Center*, 11 F.Supp.2d at 816 (granting preliminary injunction because "there is certainly grave doubt that the term 'substantial portion thereof' supplies the kind of notice requirement to avoid a finding of vagueness or whether the term is sufficient to prevent arbitrary prosecution"); Ann MacLean Massie, *"Partial Birth Abortion" Bans*, 59 U. Pitt. L.Rev. at 339 (stating that "these bans are invariably unconstitutionally vague.").

III. CONCLUSION

For three reasons, Nebraska's law banning so-called "partial-birth" abortions is unconstitutional as applied to Dr. Carhart. First, for 10 to 20 women a year the law endangers their health and lives in order to further the well-being of nonviable fetal life; that is, the law prohibits Dr. Carhart from using the safest procedure, which, for these women, is the D & X. Second, for about 190 women a year the law endangers their health and lives in order to further the well-being of nonviable fetal life; that is, the

law prohibits Dr. Carhart from using the safest procedure, which, for these women, is the D & E. Finally, the law is void for vagueness; that is, no one, including the defense experts, understand what the words "substantial portion" mean. Accordingly, I will give Dr. Carhart the permanent injunctive relief he seeks and I will declare Nebraska's law unconstitutional as applied to Dr. Carhart, his patients, and those like them.[48]

IT IS ORDERED that:

1. At the appropriate time, judgment shall be entered by separate document providing that:

> Judgment is entered for the plaintiff and against the defendants, jointly and severally. As applied to Dr. Carhart, his patients and others who are similarly situated, LB 23 (effective June 9, 1997) is declared unconstitutional regarding Carhart's method of performing D & E and D & X abortions on nonviable fetuses. The defendants, including their agents, servants and employees, are permanently enjoined from enforcing LB 23 against the plaintiff, his patients, and others who are similarly situated to the extent the law has been declared unconstitutional. The defendant Stenberg is ordered to serve a copy of the decision and judgment on all county attorneys in the State of Nebraska, and when so served such attorneys, and their agents, servants and employees, shall be permanently enjoined as

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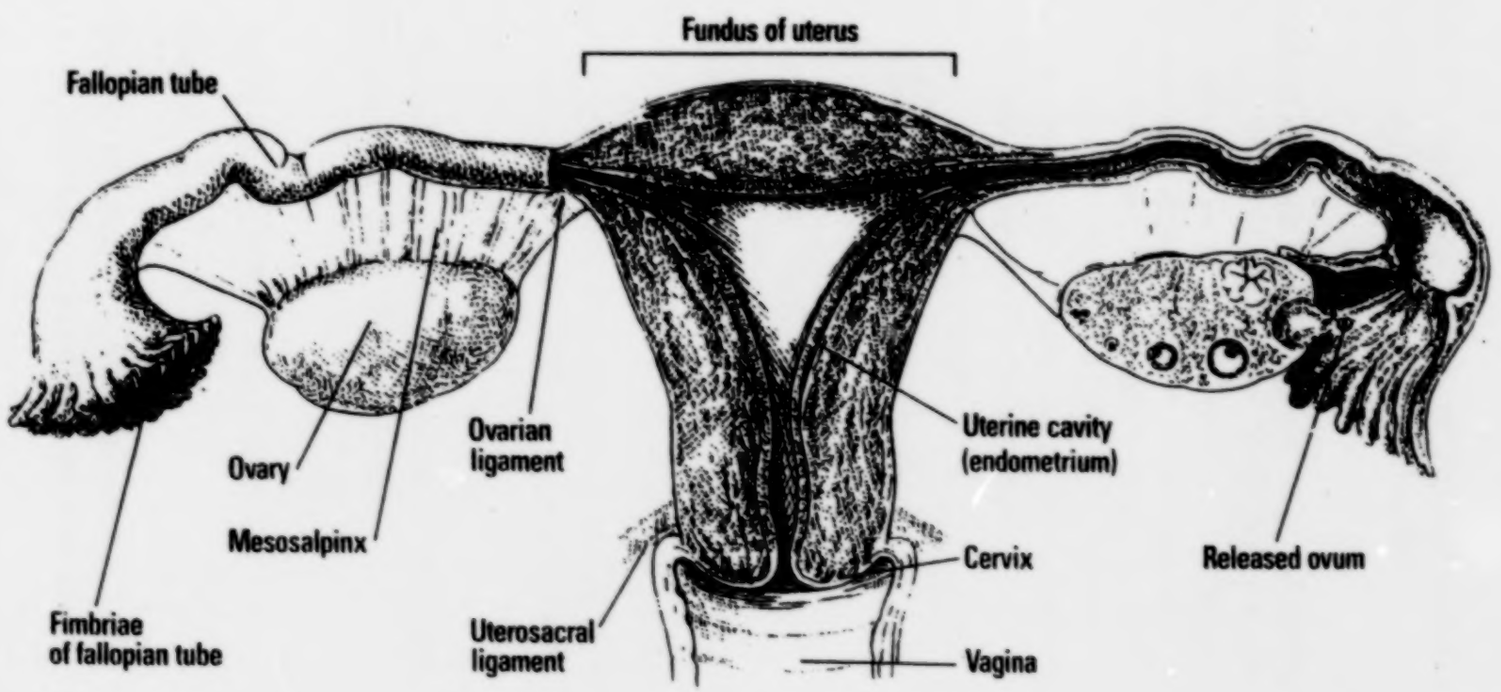
[48] For the second time, I decline the defendants' invitation to establish a new category of constitutional analysis for nonviable fetal life. *Carhart I*, 972 F.Supp. at 529. *Accord Richmond Medical Center*, 11 F.Supp.2d at 822 (stating that "*Carhart* is clearly right.")

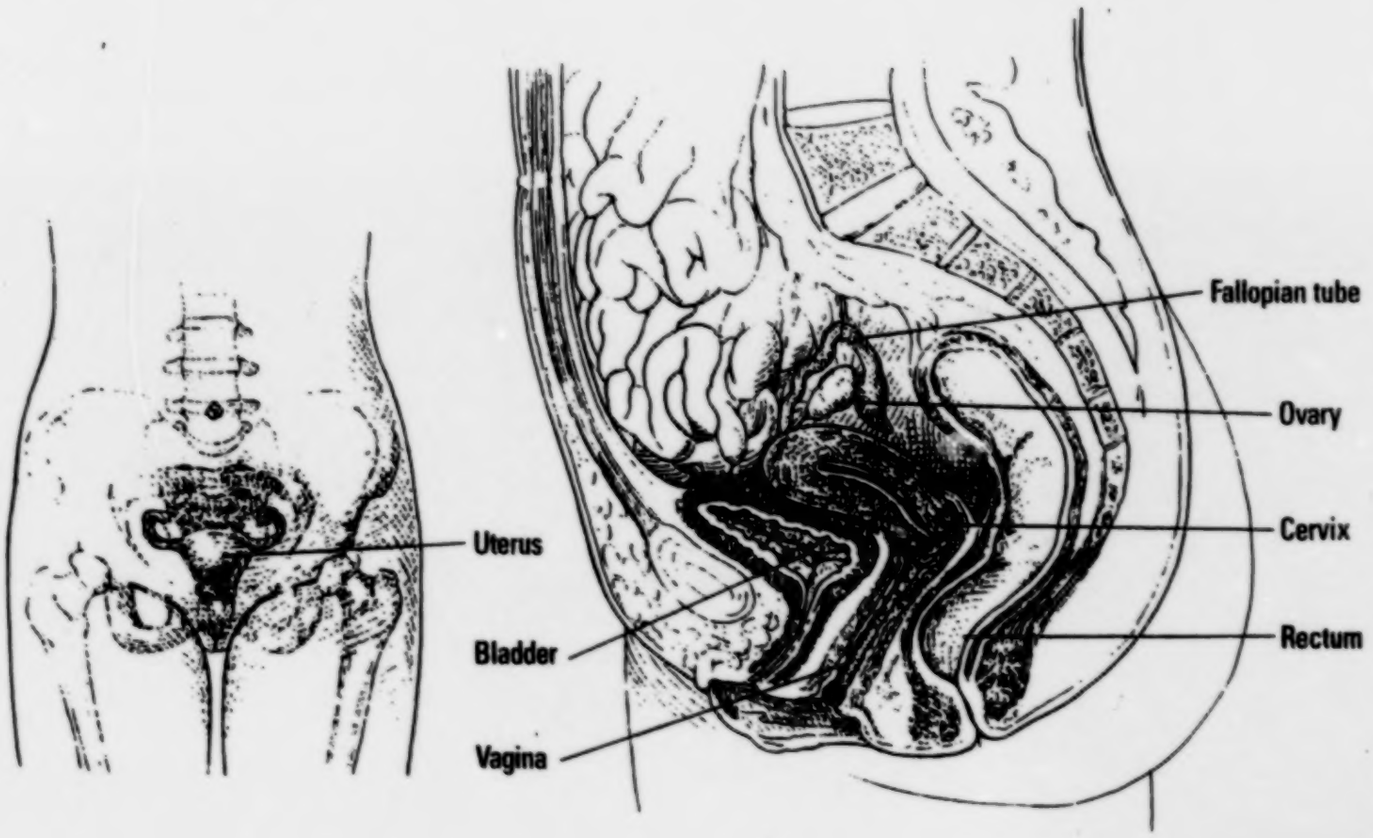
> well. *See* Fed.R.Civ.P. 65(d). Costs of this action, including reasonable attorney fees as may be awarded, are taxed to the defendants.

2. Judgment will be withheld pending resolution of the plaintiff's claim for attorney fees.

3. Plaintiff's application for attorney fees shall be submitted by July 20, 1998, and the defendants have until August 3, 1998 to respond. The parties are cautioned to comply with the Local Rules of Practice.

Pelvic Anatomy





90

EXHIBIT
34

Leroy CARHART, M.D., on behalf of himself and his patients obtaining abortions, Plaintiff,

v.

Don STENBERG, in his official capacity as Attorney General for the State of Nebraska; Mike Munch, in his official capacity as County Attorney for Sarpy County and as a representative of all county attorneys in Nebraska; and Deb Thomas, in her official capacity as Director of Regulation and Licensure of the Nebraska Department of Health and Human Services, Defendants.

No. 4:97CV3205.

United States District Court,
D. Nebraska.

Aug. 14, 1997.

Simon Heller and David Gans, New York City, Jerry M. Hug, Omaha, NE, for plaintiff.

Don Stenberg, Attorney General, Steve Grasz, Deputy Attorney General, Lincoln, NE, for defendants Don Stenberg, and Deb Thomas.

Tamra Walz, Deputy Sarpy County Attorney, Papillion, NE, for defendant Mike Munch.

MEMORANDUM AND ORDER

KOPF, District Judge.

LeRoy Carhart (Carhart), a medical doctor, seeks a preliminary injunction regarding enforcement of

Nebraska's "partial-birth" abortion law. After an evidentiary hearing, we conclude that a preliminary injunction should be issued.

We agree with the first argument raised by Carhart: Nebraska's ban on the "partial-birth" abortion procedure has the effect of subjecting Carhart's patients to an appreciably greater risk of injury or death than would be the case if these women could rely on him to perform his variant of the banned procedure on nonviable fetuses when medically advisable. Such a ban, therefore, is an "undue burden" to women seeking abortions, and it violates the Due Process Clause of the Fourteenth Amendment.

We do not reach the merits of Carhart's second argument that the statute is unconstitutionally vague. We note, however, that a similar vagueness argument was recently adopted in a persuasive opinion. *Evans v. Kelley*, No. 97-CV-71246-DT, slip op. at 48-67, 85-88 n. 38, ___ F.Supp. ___, ___-___, ___-___ n. 38 [1997 WL 471906] (E.D.Mich. July 31, 1997) (granting preliminary and permanent injunction) (*Evans*). It is unnecessary to reach this question given our resolution of Carhart's first argument, and "[a]s the U.S. Supreme Court has repeatedly cautioned, federal courts should avoid unnecessary and broad constitutional adjudication." *Id.*, slip op. at 85-86 n. 38, ___ F.Supp. at ___-___ n. 38 (citations omitted). We believe it particularly appropriate to avoid this issue until we have the benefit of a trial on the merits.[1]

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[1] The Michigan law struck down as vague by *Evans* is different from Nebraska's law in at least two important respects: Nebraska's law contains an intent requirement, and it uses the additional phrase "substantial portion thereof" when attempting to define the procedure. The *Evans* court recognized that these differences might be important. *Id.*, slip op. at 85-88 n. 38, ___ F.Supp. at ___-___ n. 38. However, the *Evans* court appointed an expert who testified that the phrase "partially vaginally delivers" was vague. *Id.* at 38-39, at ___. A similar phrase appears in Nebraska's law. Therefore, it is wise to wait for a trial on the merits before reaching this claim, particularly since neither the parties nor the court had the benefit of *Evans* at the time evidence was presented in this case.

Our reasons for the foregoing findings and conclusions are set forth in the following memorandum and order.[2] We turn to those reasons now.

I. FINDINGS OF FACT

A. The Parties

1. Plaintiff LeRoy Carhart, M.D., practices medicine and surgery in Nebraska and performs abortions in Bellevue, Sarpy County, Nebraska. (Filing 1, Compl., at 3; Filing 9, Stenberg and Thomas Answer, at 2; Ex. 16, Carhart *Curriculum Vitae*, at 1, 5.)

2. Carhart received his Doctorate of Medicine in 1973; completed his internship at Malcolm Grow USAF Hospital at Andrews Air Force Base, Maryland, in 1974; and completed his general surgery residency at Hahnemann Medical College and Hospital in Philadelphia,

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[2] We take this opportunity to compliment counsel on the quality of their advocacy. In particular, we compliment counsel for the professionalism they displayed to each other and the court.

Pennsylvania, and Atlantic City Medical Center in Atlantic City, New Jersey, in 1978. Carhart is a retired lieutenant colonel in the United States Air Force who served as chief of general surgery, chief of emergency medicine, and chairman of the department of surgery at Offutt Air Force Base in Nebraska from 1978 to 1985. As part of his duties at Offutt, Carhart supervised 20 to 25 other physicians, including obstetricians and gynecologists. (Tr. 193:25-194:5.) Carhart has been an assistant professor in the surgery departments of both Creighton University School of Medicine and the University of Nebraska Medical Center. (Ex. 16, Carhart *Curriculum Vitae*, at 2-4.) Since 1985 Carhart has operated a general medical practice with a specialized abortion facility.[3] (Tr. 82:14-21.) He performs 800 abortions each year. (Tr. 83:3.) Carhart has never attempted to become certified by a medical specialty board and currently has no hospital privileges. (Tr. 139:2-25.) He is licensed to practice medicine in eight states. (Ex. 16, Carhart *Curriculum Vitae*, at 5.)

3. Defendant Don Stenberg is attorney general of the State of Nebraska, and defendant Deb Thomas is director of the Nebraska Department of Health and Human Services Regulation and Licensure. (Filing 1, Compl., at 3-4; Filing 9, Stenberg and Thomas Answer, at 2.)

4. Defendant Mike Munch is the elected county attorney for Sarpy County, Nebraska, and is responsible

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[3] Carhart learned to perform abortions on rotation in a civilian hospital while on active duty with the Air Force. He was not permitted to perform abortions in Air Force hospitals. (Tr. 194:6-15.)

for the enforcement of criminal law within Sarpy County. (Filing 1, Compl., at 3-4; Filing 11, Munch Answer, at 1.)

B. Legislative Bill 23

5. On June 3, 1997, the Nebraska Unicameral passed Legislative Bill 23 ("LB 23") with an emergency clause making it effective upon the governor's signature on June 9, 1997. (Ex. 6.)

6. Legislative Bill 23 prohibits "partial-birth abortions" in the State of Nebraska "unless such procedure is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." LB 23 § 3(1).

7. Legislative Bill 23 defines "partial-birth abortion" as follows:

> Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. For purposes of this subdivision, the term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.

LB 23 § 2(9).

8. Legislative Bill 23 makes the "intentional and knowing performance of an unlawful partial-birth abortion" a Class III felony, as well as grounds for automatic suspension and revocation of an attending physician's license to practice medicine in Nebraska. LB 23 § 3(2) & (4).

9. "Partial-birth abortion" is not a recognized medical term. (Tr. 88:18-89:6, Carhart Test.; Tr. 216:3-13, Hodgson Test.)

C. Abortion Procedures

10. Carhart performs abortions in a clinic setting from a gestational age of 3 weeks until fetal viability,[4] with gestational age being measured from the first day of a woman's last menstrual period, as verified by ultrasound. (Tr. 83:9-84:5; 141:20-22.) Of the 800 women on whom Carhart performed abortions in 1996, 200 were past their 14th week of pregnancy. (Tr. 83:1-3; 185:14-24.) As far as he knows, Carhart is the only abortion provider in Nebraska who performs elective abortions past 16 weeks' gestation. (Tr. 132:10-18.)

11. If a woman wants an abortion after viability and the abortion is not medically indicated, Carhart refers the patient elsewhere. (Tr. 87:13-22.) If a patient comes to him

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[4] Carhart testified that fetal viability may occur around 22 weeks' gestation, but it can vary depending upon maternal habits such as drug and alcohol use and lack of prenatal care. (Tr. 174:17-175:7.)

for an abortion and "there is any concern of fetal viability," Carhart does not use his own judgment to determine viability, but instead insists on a specific referral from the patient's physician identifying fetal flaws, stating that the fetus is not viable, and stating that the patient needs an abortion. (Tr. 174:4-16.)

12. Carhart performs abortions on patients whose health, rather than life, would be preserved by having an abortion, such as those with severe renal disease, severe diabetes that has required hospitalization, and hyperemesis gravidarum, a condition characterized by constant vomiting throughout pregnancy such that the pregnant woman loses a good portion of her body weight. Carhart has also performed abortions on patients who indicated that if abortion had not been an option for them, they would have considered attempting a self-induced abortion or suicide. (Tr. 133:16-134:11.)

13. Carhart selects the abortion procedure he will use on various patients based on gestational age and other medical factors. (Tr. 84:6-12.)

14. The parties have stipulated to the admission of Exhibit 7, which is a portion of the American Medical Association's (AMA's) "Report of the Board of Trustees on Late-Term Abortion." The board of trustees prepared and submitted the report to the AMA's board of delegates in May, 1997, in response to the passage of a 1996 resolution by the delegates calling for the AMA to conduct a study of late-term pregnancy termination techniques.

(Filing 13 ¶ 2; Tr. 326:7-327:16.) Hereinafter, Exhibit 7 shall be referred to as the "AMA report."[5]

1. Suction Curettage or Vacuum Aspiration

15. The AMA report indicates that suction curettage, or vacuum aspiration, is the most common means of inducing abortion from the 6th through the 12th week of gestation. (Ex. 7, at 7:29-30.) The AMA report describes this procedure as follows:

> Prior to the procedure a pelvic examination is done to determine the size and position of the uterus. A speculum is used to visualize the cervix, a local anesthetic such as a paracervical block is administered, and the cervix is then dilated using rigid dilators (e.g., the Pratt dilator). Osmotic dilators may be used prior to the procedure. Once the cervix is sufficiently dilated, a suction tube is inserted and rotated inside the uterus to loosen and remove the contents. The suction tube may be attached to a suction machine or syringe. A curette may be used to scrape the endometrium, thereby ensuring the removal of any remaining tissue. These procedures are typically performed on an outpatient basis.

(Ex. 7, at 7:31-37 (footnotes omitted).)

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[5] Exhibit 3, a certified "rough draft transcript" of the floor debate on LB 23, and Exhibit 8, an informational booklet addressing fetal development entitled "If you are Pregnant . . . " which was prepared by the Nebraska Department of Health pursuant to state law, were also received into evidence, but not to prove the truth of the matters asserted therein. (Tr. 7:23-9:25.)

16. Carhart uses curettage[6] with vacuum aspiration from approximately the 12th through the 15th week of gestation. Carhart stated that "[a]t about the 12th or 13th week, we usually use curettage with vacuum aspiration up through the 15th, 16th week, after that 16th week, generally, it's a dilation and evacuation procedure." (Tr. 84:20-23.) At another point, Carhart stated that the "14th to 15th week" was the latest he would use the curettage with vacuum aspiration procedure. (Tr. 93:12-14.) While Carhart attempts to use curettage with vacuum aspiration in the 14th and 15th weeks of gestation, "[m]ost of the time by the 15th week, it doesn't work," and he must "use a mechanical forcep to actually grasp the fetus and remove it." (Tr. 93:14-17.)

17. Carhart uses ultrasound while conducting the vacuum aspiration procedure. Ultrasound is "an adaption of the sonar developed by the Navy in the 1930's to find the different densities of substances, usually in comparison with a known substance." (Tr. 93:22-25, Carhart Test.) Ultrasound is used to display a picture of fetal tissue and cartilage on a television screen. (Tr. 94:1-5, Carhart Test.)

18. When the vacuum aspiration procedure is used, a fetus can come through the suction tube, or cannula, intact or dismembered. Carhart uses cannulas ranging from 5 to 16 millimeters. (Tr. 95:10-24; 96:2-8.) If the tube becomes clogged during this procedure, Carhart must

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[6] Carhart describes curettage as a method of removing fetal debris, placental fragments, and potentially cancerous growths from the uterine wall, thereby reducing the risk of infection, greater bleeding, and passing fetal material into the mother's bloodstream. (Tr. 164:6-165:7.)

remove the tube to "de-clog" it, at which time the uterus will expel its contents into the vaginal cavity. (Tr. 155:18-20.)

19. The fetus is not dead before Carhart begins the vacuum aspiration procedure, and the entire fetus comes through the cannula alive in many instances. (Tr. 96:15-18; 97:16-17.)

2. Dilation and Evacuation (D & E)

20. According to the AMA report, the most common procedure for inducing abortion early in the second trimester of pregnancy, or in the 13th through 15th weeks of gestation, is dilation and evacuation, or D & E. (Ex. 7, at 8:1-10.) The AMA report describes the D & E procedure at 13 through 15 weeks' gestation as follows:

> Ultrasonography is used prior to the procedure to confirm gestational age, because the underestimation of gestational age can have serious consequences during a D & E procedure. D & E is similar to vacuum aspiration except that the cervix must be dilated more widely because surgical instruments are used to remove larger pieces of tissue. Osmotic dilators[7] are usually used. Intravenous fluids and an analgesic or sedative may be administered. A local anesthetic such as a paracervical block may be

[7] Carhart testified that the type of osmotic dilator he uses is seaweed that has been sterilized and medically prepared. He also referred to this osmotic dilator as laminaria. (Tr. 98:1-4; 99:1-3.) With this particular procedure, Carhart waits 12 to 72 hours before completing the abortion in order to allow for adequate dilation. (Tr. 98:6-14.)

> administered, dilating agents, if used, are removed, and instruments are inserted through the cervix into the uterus to remove fetal and placental tissue. Because fetal tissue is friable and easily broken, the fetus may not be removed intact. The walls of the uterus are scraped with a curette to ensure that no tissue remains.[8] In pregnancies beyond 14 weeks, oxytocin is given intravenously to stimulate the uterus to contract and shrink.

(Ex. 7, at 8:10-19 (footnotes omitted).)

21. According to the AMA report, the D & E procedure is also used from 16 to 24 weeks' gestation, with the following variations:

> Dilation and evacuation procedures performed in the mid-to late-second-trimester involve the preoperative use of laminaria or osmotic dilators (rather than surgical dilators) which are inserted in the endocervical canal in order to dilate the cervix. The procedure is usually performed under local anesthesia, using sedation and paracervical block. Intracervical vasopressin is often used to minimize bleeding, and high dose oxytocin is administered intravenously prior to the procedure. Fetal tissue is extracted through the use of surgical instruments, followed by extraction of placental tissue and subsequent curettage. Because the fetus is larger at this stage of gestation (particularly the

[8] Carhart testified he also vacuum aspirates the uterus to ensure that no tissue fragments are left on the uterine wall. (Tr. 98:15-18.)

(Ex. 7, at 8:10-19 (footnotes omitted).)

> head), and because bones are more rigid, dismemberment or other destructive procedures are more likely to be required than at earlier gestational ages to remove fetal and placental tissue. Some physicians use intrafetal potassium chloride or digoxin to induce fetal demise prior to a late D & E (after 20 weeks), to facilitate evacuation.

(Ex. 7, at 8:28-38 (footnotes omitted).)

22. Carhart uses the D & E procedure "after that 16th week" of gestation, combined with prostaglandin to aid in cervical dilation and other medication to cause the uterus to contract. (Tr. 84:24-85:16.)

23. Carhart's method of mechanically removing the fetus from the uterus during D & E involves using ultrasound in order to observe the fetus and the surrounding area; using vacuum aspiration or forceps to rupture the membranes; and then grasping a portion of the fetus in order to bring it out of the uterus with long-handled forceps. (Tr. 100:1-14.) After the membranes are ruptured and the uterus begins to contract, a fetal extremity will often prolapse through the cervical os such that Carhart must dismember the extremity. He then attempts to bring the feet or skull down, dismembering the remaining arm or other extremities in the process. (Tr. 110:6-9; 118:9-12.)

24. When Carhart performs a D & E, he inserts an instrument inside the uterus, grabs a portion of the fetus, pulls it through the cervical os, and dismembers various fetal parts by the traction created between the instrument and the cervical os. (Tr. 116:2-10.) The tearing of fetal

parts from the fetal body is accomplished by means of traction at the cervical os.[9]

25. Carhart's description of this procedure *is* consistent with that of Dr. Jane Hodgson, founding fellow of the American College of Obstetrics and Gynecology, past president of the Minnesota Ob/Gyn Society, and author of 50 to 100 published articles on abortion. (Tr. 196:16-24; 197:11-13; Ex. 14, Hodgson *Curriculum Vitae*, at 2.)[10]

26. Through the 19th week of gestation, ultrasound confirms, by indicating a fetal heartbeat, that the fetus is "invariably" alive when Carhart performs a D & E, and via ultrasound Carhart has observed fetal heart activity with "extensive parts of the fetus removed." (Tr. 100:15-22; 109:4-23; 110:12-14; 119:2-9; 195:9-11.) Dr. Hodgson also testified that the fetus may still have a

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[9] The cervical os is the mouth or opening of the cervical canal. STEDMAN'S MEDICAL DICTIONARY 996 (4th unabridged law. ed.1976).

[10] Dr. Hodgson received her M.D. and M.S. in obstetrics and gynecology from the University of Minnesota School of Medicine; completed her internship and residency at the Jersey City Medical Center in New Jersey; and completed a fellowship in obstetrics and gynecology at the Mayo Clinic in Rochester, Minnesota. (Ex. 14, Hodgson *Curriculum Vitae*, at 2.) Dr. Hodgson has performed or supervised at least 30,000 abortions as the director of numerous medical clinics throughout the country since 1973, and has delivered at least 5,000 babies. (Tr. 197:14-20.) Dr. Hodgson has been a board member of Planned Parenthood, belongs to the National Abortion Federation and the Abortion Rights Council, and is currently a board member for the Center For Reproductive Law & Policy, for whom Plaintiff's lawyers also work. (Ex. 14, Hodgson *Curriculum Vitae*, at 3.)

heartbeat while extremities are being removed. (Tr. 211:4-7.)

3. Intact Dilation and Evacuation (Intact D & E or D & X)

a. The Procedure

27. In an effort to minimize perforation of the uterus or cervix by instruments used during a D & E or from piercing caused by fetal parts, some physicians use "a form of D & E that has been referred to in the popular press as intact dilation and extraction (D & X)." (Ex. 7, at 8:40-42.)

28. For any abortion "over 15 weeks[']" gestation, Carhart intends and prefers to remove the fetus intact by using the intact D & E procedure, although it is "usually the 19th- and 18th- and early 20-week fetuses that come out intact." (Tr. 100:9-10; 101:3-5; 184:1-23.)

29. Citing the American College of Obstetricians and Gynecologists' January, 1997, statement on intact dilation and extraction, the AMA report describes the intact D & X as "deliberate dilation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus." (Ex. 7, at 8:42-46.)

30. In contrast to the AMA's description of the intact D & E or D & X procedure, Carhart does not perform instrumental conversion of the fetus to a footling breech, but removes the fetus headfirst or feet first,

depending on how the fetus is positioned. (Tr. 102:19-24; 111:3-6; 156:18-157:19.) Carhart prefers the feet-first presentation because less dilation is required and "that's the absolute safest scenario." (Tr. 192:18-193:2.)

31. When Carhart performs this procedure, he drains the amniotic fluid before beginning the evacuation procedure in order to avoid amniotic fluid embolus, which he views as a serious and common cause of maternal death or complications. (Tr. 102:1-6.) If possible, Carhart then attempts to grasp and divide the umbilical cord of the fetus, which is the structure that transports arterial and venous blood between the fetus and the placenta, giving the fetus its only source of oxygen. If he divides the cord, the fetus will usually die within 6 to 10 minutes. (Tr. 111:11-20; 189:20-24.) There are instances in which Carhart cannot divide the cord because he is unable to reach it due to fetal position or spontaneous protrusion of a fetal part through the cervical os, preventing access to the cord. (Tr. 111:21-25; 190:17-25.)

32. If Carhart succeeds in dividing the umbilical cord, he does not wait for fetal death to occur before continuing the procedure because once the membranes have been ruptured and drugs administered to induce contractions, each minute of delay causes maternal blood loss. (Tr. 190:2-16.)

33. When the fetus is presented feet first, Carhart, using forceps, pulls the feet of the living fetus from the uterus into the vaginal cavity and then pulls the remainder of the fetus, except the head, into the vaginal cavity to a point where the base of the fetal skull is lodged in the uterine side of the cervical canal. (Tr. 110:19-22; 112:2-12.)

At that point, the size of the head will not permit him to pull it through the cervical canal into the vaginal cavity. To decompress the fetal skull and evacuate the contents in order to pull it through the cervical canal, Carhart uses an instrument to either tear or perforate the skull to allow insertion of a cannula and removal of the cranial contents. Sometimes he will crush the skull rather than pierce it in order to reduce the size of the skull. (Tr. 104:2-6; 112:13-16.) Brain death occurs sometime during this two- to three-second reduction procedure, but fetal heart function may continue for several seconds or minutes after the fetus's skull is decompressed. (Tr. 112:17-113:7.)

34. While he intends to remove the fetus intact for any abortion performed past 15 weeks' gestation, only about 5 or 10 percent of the fetuses Carhart aborts are delivered totally intact due to softness of the fetal tissue such that it is easily fragmented. Carhart normally cannot perform this procedure before the 16th week of gestation because the fetal body parts tear apart during the process. (Tr. 115:9-18; 184:10-19.)

35. Some patients have requested that Carhart perform an intact D & E for personal reasons, and some physicians have asked to have the fetus as intact as possible for genetic study when the entirety of fetal deformities is unknown. (Tr. 123:9-25.)

b. Fetal Death

36. After the 20th week of gestation, Carhart attempts to induce fetal death 48 to 72 hours before beginning the abortion procedure with an ultrasound-

guided intracardiac fetal injection of digoxin and lidocaine, both of which reduce and stop cardiac activity. (Tr. 119:10-25.) Carhart attempts to inject the drugs through the mid-line of the maternal abdomen where there are fewer blood vessels and he is less likely to encounter colon or small bowel contents. (Tr. 186:14-23.) Carhart attempts to inject the fetal thoracic cavity or heart, whereupon fetal death will occur within 15 to 20 minutes, but sometimes is able to inject only the amniotic sac, causing fetal death approximately 24 hours later. (Tr. 187:1-6.)

37. Carhart attempts to induce fetal death in this manner to achieve softness and compression of the fetal tissue and skull and to provide mental comfort to his patients. (Tr. 120:2-19.)

38. Carhart does not attempt to induce fetal demise in this manner during the 16- to 20-week time frame because the waiting time between the injection and performance of the procedure is only 12 to 24 hours, and not much fetal tissue change occurs; Carhart finds that many of his patients in the earlier stages of pregnancy are more apprehensive of the fetal injection; and in the earlier stages of pregnancy, the uterus is smaller and the risks of the needle penetrating the bowel and of missing the fetus and injecting the medication into maternal circulation are greater. (Tr. 120:20-122:3; 188:2-11.) Furthermore, Carhart sees patients for whom digoxin and lidocaine are medically contraindicated during any part of their pregnancy, such as those who have seizure disorders,[11] heart disease,

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[11] Carhart testified that lidocaine can induce seizures in people, so treating someone who has a seizure disorder with a

or who are already taking either medication such that an injection would exceed the maximum recommended dosage. (Tr. 122:20-123:4.)

39. Dr. Hodgson testified that in all forms of abortion, the point at which fetal demise occurs is "extremely variable." (Tr. 217:17-18.) In her opinion, lack of fetal heartbeat is the best available measure for determining fetal demise, and fetal death by that measurement can be quite protracted. (Tr. 219:16-25.)

C. Benefits of the Intact D & E or D & X

40. The AMA report states that "[t]his procedure may minimize trauma to the woman's uterus, cervix, and other vital organs. Intact D & X may be preferred by some physicians, particularly when the fetus has been diagnosed with hydrocephaly or other anomalies incompatible with life outside the womb." (Ex. 7, at 8:46-49.)

41. Carhart's intent to remove the fetus intact for any abortion performed past 15 weeks' gestation is aimed at reducing the chances of maternal complications or death. (Tr. 100:9-10; 101:7-102:6; 124:16-125:2.) Intact removal of the fetus lowers maternal complications by preventing sharp fragments, such as pieces of long bone or skull fragments, from passing through the cervical os without some kind of covering or protection. When the fetus is removed intact, its bones are covered by fetal

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medication that could trigger further seizures would be an "additional risk." (Tr. 170:16-171:1.)

tissue, causing less trauma to the cervix. (Tr. 101:3-16; 131:1-7.)

42. Carhart also stated that intact removal of the fetus minimizes the risk of damage to maternal structures from repeated use of instrumentation in the uterine cavity. (Tr. 107:18-108:13; 131:1-23.) The more times Carhart must enter the uterus with an instrument, the more the complication rate multiplies. (Tr. 179:13-22.) The intact D & E or D & X procedure involves fewer insertions of forceps or other foreign objects into the uterus than a D & E resulting in dismemberment of the fetus. (Tr. 179:23-180:2.)

43. Performing the intact D & E or D & X procedure also allows a more accurate assessment of whether the uterine cavity has been emptied. Fetal and placental debris remaining in the uterus – as is possible with a D & E involving dismemberment – can cause infection, greater bleeding, and risk of absorption of the fetal tissue into the maternal bloodstream, as explained in more detail below. (Tr. 165:4-10; 183:4-24.)

44. Dr. Hodgson described leaving fetal parts in the uterus as a potentially "horrible complication" that can cause infection and often results in perforation of the uterine wall by bony splinters. (Tr. 211:19-24.)

45. Carhart's method of intact removal of the fetus and evacuation of the contents of the fetus's brain when it is reachable through the cervical os directly outside the uterus also helps prevent "disseminated intravascular coagulopathy" (DIC), that is, the absorption into the mother's bloodstream of fetal brain, skin, and blood tissue through the blood sinuses or cavities in the uterine

wall, thereby causing the mother's own coagulation factors to stop working. According to Carhart, DIC is another cause of maternal death or complications, with the risk of such a complication being less than 1 in 1,000. (Tr. 101:16-25; 102:7-14; 158:13-159:14.) Compression of the fetal skull also enables Carhart to obtain as little cervical dilation as possible in order to reduce other maternal complications, such as incompetent cervix, at a later date. (Tr. 103:2-17.)

46. In Carhart's opinion, performing an intact D & E is much safer than performing a D & E that does not result in removal of an intact fetus. (Tr. 108:14-18.) Although she has not intentionally[12] performed an intact D & E, Dr. Hodgson believes the procedure is a technological advance that has received favorable reports from those who are performing the procedure. (Tr. 212:8-22.) Dr. Hodgson believes the D & X procedure is "an advance in technology" because by removing the fetus intact there is "less instrument manipulation," which means, "of course, the higher your safety." (Tr. 212:4-22.)

d. Number of Intact D & Es or D & Xs Performed by Carhart in Which Fetal Life Could Not be Terminated Before Delivery

47. In 1996, Carhart had 180 to 190 patients with a live fetus in utero for whom it was medically inadvisable

[12] Dr. Hodgson described it as a "victory" when an intact fetus is removed during a D & E without the intent to do so. (Tr. 211:8-12.)

to inject digoxin and lidocaine to terminate the life of the fetus and on whom he began what he intended to be an intact D & E. (Tr. 189:1-12.) Of those 180 or 190 patients, Carhart removed approximately 20 fetuses intact, and 10 of those 20 presented themselves feet first. (Tr. 191:10-22.)

4. The Haskell D & X

48. In *Women's Medical Professional Corp. v. Voinovich*, 911 F.Supp. 1051 (S.D.Ohio 1995), the court considered the constitutionality of an Ohio law banning the use of the so-called "Dilation and Extraction" (D & X) procedure. One of the plaintiffs, Dr. Martin Haskell, used a method of abortion from 20 to 24 weeks' gestation characterized by various parties as the D & X procedure[13] and performed as follows:

> On the first and second days of the procedure, Dr. Haskell inserts dilators into the patient's cervix. On the third day, the dilators are removed and the patient's membranes are ruptured. Then, with the guidance of ultrasound, Haskell inserts forceps into the uterus, grasps a lower extremity, and pulls it into the vagina. With his fingers, Haskell then delivers the other lower extremity, the torso, shoulders, and the upper extremities. The skull, which is too big to be delivered, lodges in the internal

[13] A variant of the procedure was also used extensively by Dr. James McMahon before his death in 1995. *See Partial Birth Abortion Ban, 1995: Hearings on H.R. 1833 Before Senate Judiciary Committee*, 104th Cong. 1st Sess., *available* in Westlaw 1995 WL 685998 (F.D.C.H.) (database USTESTIMONY) (statement of Dr. Mary Campbell) (Nov. 17, 1995) (describing her observations of the procedure used by Dr. McMahon).

> cervical os. Haskell uses his fingers to push the anterior cervical lip out of the way; then presses a pair of scissors against the base of the fetal skull. He then forces the scissors into the base of the skull, spreads them to enlarge the opening, removes the scissors, inserts a suction catheter, and evacuates the skull contents. With the head decompressed, he then removes the fetus completely from the patient.

Id. at 1066 (footnotes omitted). Dr. Haskell routinely cuts the umbilical cord before penetrating the skull with scissors. *Id.* at 1066 n. 17.

5. Labor Induction

49. Labor induction, an alternative to D & E and what has been described above as the intact D & E or D & X, may also be used to induce abortion during the 16th to 24th week of gestation. Labor may be induced by use of hypertonic solutions such as urea or saline, or prostaglandin. (Ex. 7, at 9:1-4.)

50. The use of saline to induce labor requires insertion of a needle through the abdomen and injection of the amniotic sac with a concentrated salt solution, which causes fetal demise and induces uterine contractions. Over a period of several hours, the uterine contractions cause dilation of the cervix and expulsion of the contents of the uterus. (Ex. 7, at 9:5-8.)

51. Urea is a nitrogen-based solution that causes fetal demise when injected into the amniotic sac and is typically followed by administration of prostaglandin to induce uterine contractions which will expel the contents of the uterus. (Ex. 7, at 9:8-12.)

52. Carhart does not perform saline or prostaglandin induction, and he does not perform inductions at all during the second trimester of pregnancy because he believes induction is medically contraindicated as a method of abortion. (Tr. 86:2-7; 125:3-126:1; 126:18-19.) Carhart believes induction during the second trimester is too uncontrolled – that is, the procedure can take over a week to complete; women have reactions to the drugs used during the procedure; and a segment of the population cannot undergo induction because of medical conditions such as hypertension, heart disease, or diabetes. (Tr. 125:6-126:1.) Carhart is aware of other physicians in Nebraska who perform abortions by induction, but only for maternally or fetally indicated abortions. (Tr. 126:2-4; 132:1-9.)

53. According to Stanley K. Henshaw, deputy director of research at the Alan Guttmacher Institute (AGI) in New York, statistical studies with which he is familiar indicate that abortions by induction are performed primarily in a hospital setting.[14] (Tr. 74:20-25; 76:20-22.) The Centers for Disease Control and Prevention (CDC) recognizes the accuracy of the data AGI collects. (Tr. 46:8-21.)

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[14] Dr. Henshaw received his Ph.D. in sociology from Columbia University and his A.B. in physics from Harvard. The Alan Guttmacher Institute is a nonprofit corporation for research and public education on issues relating to reproductive health services. (Ex. 15, Henshaw *Curriculum Vitae*, at 1; Tr. 44:15-25.) Dr. Henshaw has written approximately 40 to 50 articles on studies he has conducted related to abortion, and his studies have included secondary analysis of existing data. (Tr. 45:9-17.) Dr. Henshaw has been a member of the National Abortion Federation. (Ex. 15, Henshaw *Curriculum Vitae*, at 2.)

6. Hysterotomy and Hysterectomy

54. Other abortion procedures available, but not routinely used, during 16 to 24 weeks' gestation are hysterectomy and hysterotomy. According to the AMA report, "maternal mortality and morbidity associated with these procedures are significantly greater than those associated with other procedures used to induce abortion." (Ex. 7, at 9:14-16.)

55. Hysterotomy is major surgery and must be performed in a hospital setting. General anesthesia or anesthesia administered by epidural or spinal injection is necessary. The procedure consists of surgical delivery of the fetus through an incision in the abdomen and uterine wall, after which the fetus is removed, the umbilical cord cut, and the placenta removed. (Ex. 7, at 9:16-20.)

56. Hysterectomy "is appropriate in cases in which there is a preexisting pathology, such as large leiomyomas or carcinoma in situ of the cervix." (Ex. 7, at 9:20-22.)

57. Carhart does not perform hysterotomy or hysterectomy as methods of abortion, but he is aware of other physicians in Nebraska who perform abortions by these methods when an abortion is maternally or fetally indicated. (Tr. 86:2-9; 127:17-23; 132:1-9.)

D. Dr. Riegel

58. Defendants presented Dr. Christopher Riegel, an obstetrician, gynecologist, and infertility specialist from Dallas, Texas, as an expert witness to challenge the testimony presented by Drs. Carhart and Hodgson, discussed

in detail above. Dr. Riegel received his medical degree from the University of Texas in 1987 and completed a one-year internship in pediatrics at Children's Medical Center in Dallas in 1988 and a four-year internship and residency in obstetrics and gynecology at Parkland Hospital at the University of Texas before entering private practice in 1992. Dr. Riegel became board certified in obstetrics and gynecology in 1995. (Tr. 232:13-234:9.)

59. Dr. Riegel does not perform abortions due to moral objections and claims to be familiar with abortion procedures, risks, complications, and contraindications only from reading technical bulletins and textbooks and by becoming, during his service as chief resident in labor and delivery, "acquainted with what goes on" in medically indicated induction abortions of fetuses having malformations incompatible with life. His experience consists of attending at abortions that were already in progress when he arrived to complete the procedure. (Tr. 236:7-8; 238:12-239:8; 274:15-20; 275:16-22; 277:4-17.) Dr. Riegel has never observed a D & E abortion because he has "chose[n] not to be associated with them." (Tr. 276:11-20; 276:23-277:3.) Dr. Riegel testified that the intact D & E or D & X procedure is not medically recognized and in fact "does not exist." (Tr. 295:17-297:25.)

60. Dr. Riegel testified it is generally medically accepted that a fetus is dead if its heart stops beating (Tr. 236:14-20); injection of potassium chloride or digoxin into the heart of a fetus to cause fetal demise is generally done at 19 weeks' gestation or more (Tr. 244:8-245:4); in the hands of a skilled operator, the risk of perforating the maternal bowel or injecting the mother with digoxin or

potassium chloride during such a procedure is "inconsequential" (Tr. 245:9-22); the risk of complications for a mother with a preexisting seizure or heart disorder from using such an injection to cause fetal demise is nonexistent, "rare," "low," or "minuscule" (Tr. 247:22-249:22); there is no maternal medical advantage to injecting a substance into a fetus while it is in the uterus in order to kill the fetus before removing it (Tr. 250:3-22); there is no maternal medical advantage to partially delivering the fetus alive, killing it, and then completing delivery, with the latter scenario involving the "blind" use of a sharp instrument in the vagina accompanied by risk of damage to the urethra, bladder, vaginal wall, cervix, and uterus (Tr. 235:13-18; 256:6-257:24; 292:4-5); no type of fetal tissue or amniotic fluid should enter the mother's bloodstream (Tr. 259:4-9); beginning at 16 weeks' gestation, Dr. Riegel uses induction instead of D & E to remove dead fetuses from the uterus, and if the patient has heart disease, diabetes, renal disease, or a prior Cesarean section, he refers her to a high-risk obstetrician (Tr. 264:17-19; 266:1-24; 272:13-15; 293:15-23); since 1988 Dr. Riegel has delivered by induction 10 to 20 demised fetuses at 16 weeks' gestation or later (Tr. 303:24-304:5); and in his geographical area of practice, it is generally accepted that amniocentesis at 13 to 18 weeks' gestation is performed only by high-risk obstetricians (Tr. 279:24-25; 284:25-285:5).

61. With regard to induction by prostaglandin injection, a process which requires hospitalization, Dr. Riegel described the side effects of nausea, vomiting, diarrhea, and fever that accompany the injections the patient

receives every three hours and the 8- to 36-hour time frame the induction procedure requires. (Tr. 306:5-307:23.)

E. Credibility of Witnesses Giving Medical Testimony

62. Having observed the witnesses' demeanor and listened to their testimony, the court finds the testimony of Drs. Carhart and Hodgson to be credible based on their extensive training, experience, and knowledge of abortion procedures, whereas Dr. Riegel's testimony regarding abortion procedures is generally not credible. Putting aside each witness's views about the morality of abortion, the court's judgment of the strength of the witnesses' medical testimony is based solely on general indicia of credibility such as demeanor, candor, and each witness's training, experience, and knowledge about medicine in general and abortion in particular.

63. Dr. Riegel has never observed or performed a D & E. He has only completed medically indicated induction abortions of fetuses having malformations incompatible with life in situations where the abortion was already in progress when he arrived on the scene. This limited experience occurred when he was a medical resident. Furthermore, as the AMA report proves, (Ex. 7, at 8), Dr. Riegel was poorly informed regarding use of the intact D & E or D & X procedure when he stated that the procedure – which is, after all, the focus of this case – simply "does not exist." (Tr. 297:22-25.)

F. Statistical Risks and Frequency Associated With Abortion Procedures

64. Overall maternal mortality rates for the D & E, labor induction, and hysterectomy/hysterotomy methods of abortion at 13 weeks' gestation or later are 51.6 per 100,000 abortions for hysterectomy/hysterotomy, 7.1 per 100,000 abortions for labor induction, and 3.7 per 100,000 abortions for D & E. Mortality rates resulting from labor induction and D & E performed at 16 to 20 weeks are 7.9 and 6.5 respectively, and 10.3 and 11.9 respectively at 21 weeks or more. (Ex. 7, at 10, tbl. 4: Maternal Mortality Rates for Induced Abortion Procedures at 13 Weeks' Gestation or Later, U.S., 1974-1987.) The AMA report summarizes these statistics as follows: "Maternal mortality rates, overall, are higher for labor induction than D & E (7.1 and 3.7, respectively), but mortality rates resulting from labor induction and D & E are comparable for induced abortions performed at 21 weeks or more (11.9 and 10.3)." (Ex. 7, at 9:39-41; 11:28-30.)[15] Dr. Hodgson stated that induction beyond weeks 18 to 20 "can be made as safe" as the D & E procedure resulting in dismemberment. (Tr. 212:1-3.)

65. While concluding that more systematic research is needed on complication rates associated with various abortion procedures performed at 13 weeks' gestation

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[15] Carhart stated that the complicating effects of anesthesia use during induction were responsible for one-third of the total deaths occurring as a result of abortion. It is not clear whether this was factored into the AMA report's statistics on the risk of the induction procedure. If not, the risk of induction would be higher than indicated in the AMA report. (Tr. 180:14-181:18.)

and beyond, the AMA report cited statistics from the "best available national data on complications" collected during the 1970s by the Joint Program for the Study of Abortion, sponsored by the Population Council and the CDC. According to the report, the complication rate associated with vacuum aspiration was 2 per 1000 procedures; D & E had a complication rate of 7 per 1000 procedures; labor induced by saline or prostaglandin injection had rates of 21 and 25 per 1000 procedures respectively; and abortion methods involving major surgery had the highest rate of complications. (Ex. 7, at 10:20-26; 10:43-48; 11:30-31.)

66. Forcing a woman to wait until post-20-weeks' gestation so that Carhart may be able to achieve fetal demise prior to performing an abortion drastically increases the risk of complications. According to the studies with which Carhart is familiar, abortion at the earliest stage is 35 times safer than childbirth as far as complications are concerned. By the 20th week, the risk of complications from abortion approximately equals that of childbirth. (Tr. 135:18-136:9, Carhart Test.; Tr. 59:9-10, Henshaw Test.)

67. The complication rate from abortion increases by about 20 percent for each week of gestation past eight weeks. (Tr. 59:11-14, Henshaw Test.)

68. According to his analysis of data from the Nebraska Department of Health and Human Services, Dr. Henshaw opined that D & E is the prime method of abortion performed in Nebraska after the first trimester of pregnancy. Of the 5,214 reported abortions in Nebraska in 1996, 5,161 were performed by suction curettage, the

prime method for first trimester abortions; 550 were performed by "sharp curettage" which were "most likely D & E's"; no inductions were performed; and 49 abortions recorded as "other" were most likely drug-induced abortions prior to eight weeks' gestation. (Tr. 49:4-50:9; Ex. 9, Neb.1996 Statistical Report of Abortions at 2, 4 (tbls.1, 5).)

69. Nationwide approximately 86 percent of abortions past 15 weeks are performed by curettage, or D & E, while induction is performed in less than 10 percent of abortions past 15 weeks. (Tr. 50:15-51:9; Ex. 17, 1992 Abortion Surveillance Report, tbl. 16, reported legal abortions, by weeks of gestation and type of procedure – U.S., 1992 (Centers for Disease Control 1992).)

70. The number of curettage, or D & E, procedures reported in Nebraska and across the nation also includes the intact D & E or D & X,[16] so there is "no way to quantify how many of the D & X abortions are done based on the statistics collected by the State [of Nebraska] or the CDC." (Tr. 52:1-5, Henshaw Test.)

71. According to a study by Dr. Henshaw, only 25 abortions, or .4 percent of the total, were performed in Nebraska hospitals in 1992, and only three Nebraska hospitals reported performing abortions that year. Two of the three indicated a referral must be made by an attending physician, and one hospital did not answer the question, leading Dr. Henshaw to conclude that a woman

[16] Carhart testified that he records intact D & E or D & X procedures under "Dilation and evacuation (D & E)," (Ex. 11), or "suction curettage," (Ex. 12), on various Nebraska abortion-reporting forms. (Tr. 128:1-129:24.)

cannot arrange an abortion directly with a Nebraska hospital. Although no such information was requested in the 1992 survey, one Nebraska hospital reported that abortions were permitted only for therapeutic reasons. (Tr. 55:10-56:19.)

G. Fear of Prosecution

72. Carhart fears prosecution under LB 23 because the Nebraska Attorney General's Office and the State Department of Health are both aware of, and have investigated, his performance of abortions in the past. (Tr. 136:10-137:22; Ex. 20, Letter from Att'y Gen.'s Office to Carhart of 11/22/95; Ex. 21, Letter from State Dep't of Health investigator to Carhart att'y of 10/9/96.)[17]

II. CONCLUSIONS OF LAW

Carhart asserts for himself and his female patients that Nebraska's ban on "partial-birth abortions" is invalid under the Due Process Clause of the Fourteenth Amendment because it prevents Carhart's patients from choosing, with his advice, a safe and desired method of terminating a pregnancy before viability.

To evaluate this argument, we must first address issues of jurisdiction, ripeness, and standing. Next we must clarify which abortion procedures Carhart does and does not perform. We must also decide whether Carhart's challenge to Nebraska's law is "facial" or "as applied."

[17] These exhibits were received to the extent they are relevant to Carhart's fear of prosecution. (Tr. 6:18-7:23; 9:19-21.)

Then we must set forth the standards governing the granting of preliminary injunctions. Finally, we must apply the preliminary-injunction standards to the facts presented at the evidentiary hearing. We turn now to these tasks.

A. Jurisdiction, Ripeness, and Standing

We have jurisdiction because Carhart attacks the constitutionality of a state statute under the United States Constitution. As a result, federal-question jurisdiction exists under 28 U.S.C. § 1331. *See, e.g., Women's Med. Prof'l Corp. v. Voinovich*, 911 F.Supp. 1051, 1058 (S.D.Ohio 1995), appeal argued, Nos. 96-3157 & 96-3159 (6th Cir. May 2, 1997) (district court had federal-question jurisdiction over action brought by doctor which challenged constitutionality of state law prohibiting "D & X" abortions) (WMPC).

In addition, this case is ripe because Carhart faces a significant risk of criminal prosecution and license revocation regarding at least 10 to 20 "D & X" procedures performed annually on nonviable fetuses. Moreover, Carhart tries to do the banned procedure for each of his patients between the 16th and 20th week of pregnancy, and he performs approximately 190 abortions during that time. (Tr. 185-186, 189.) The ban therefore has a direct and immediate impact upon Carhart and about 190 of his patients.

The State of Nebraska has admitted that 10 to 20 abortions performed by Carhart in 1996 clearly would have been prohibited by Nebraska's law. (Tr. 366.) Moreover, Carhart's abortion practices have been the subject of

previous investigation by the defendants. Consequently, Carhart may sue for pre-enforcement review of the law. *Id.* (citing *Doe v. Bolton*, 410 U.S. 179, 188, 93 S.Ct. 739, 745-46, 35 L.Ed.2d 201 (1973)).

Finally, Carhart has the necessary standing to raise both his own rights and the rights of his patients. *Id.* To the extent that Nebraska's ban prohibits him from practicing medicine in a safe and effective manner because it requires him to subject his patients to increased medical risk, Carhart has a strong personal stake in the argument. Moreover, Carhart has third-party standing to assert the interests of his patients because (1) a unique fiduciary-like relationship exists between doctor and patient; and (2) the pregnant women who are the doctor's patients have significant obstacles to bringing suit on their own, such as a desire for privacy and the likelihood that their claims would be mooted by the time-sensitive nature of pregnancy and abortion. *Id.* (citing *Planned Parenthood v. Casey*, 505 U.S. 833, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992); *Singleton v. Wulff*, 428 U.S. 106, 96 S.Ct. 2868, 49 L.Ed.2d 826 (1976)). *See also Evans*, No. 97-CV-71246-DT, slip op. at 44, ___ F.Supp. at ___ ("[T]he Supreme Court . . . [has] explicitly held that doctors who perform abortions are entitled to third-party standing to assert the rights of women seeking abortions.") (citations omitted).

B. What Carhart Does and Does Not Do

Carhart does not intentionally perform abortions on viable fetuses.[18] On the contrary, when he has a concern

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[18] According to a book published by the State of Nebraska, a fetus born before 23 weeks has only a 10 percent chance of

about viability Carhart requires an independent medical assessment to decide whether the fetus is viable. "Viability" occurs when "there is a reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial support." *Colautti v. Franklin*, 439 U.S. 379, 388, 99 S.Ct. 675, 682, 58 L.Ed.2d 596 (1979). *See also Casey*, 505 U.S. at 870, 112 S.Ct. at 2816-17 (viability is "the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman").

Moreover, while Carhart performs a similar procedure, he does not do the precise procedure pioneered by Dr. Martin Haskell commonly (although not medically)[19] thought of as "partial-birth abortion." *Compare WMPC*, 911 F.Supp. at 1066 (describing the Haskell "D & X" procedure) *with Report of Am. Med. Ass'n* at 8 & n. 19 (Ex. 7) (describing "intact dilation and extraction" or "D & X"). The procedure performed by Dr. Haskell has four

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survival. (Ex. 8, at 11.) Dr. Riegel, the defense expert, believes the number "may even be lower than that." (Tr. 311:7-8.) The State of Nebraska also believes a fetus born before 20 weeks has no chance of survival, while a fetus born at 24 weeks has about a 55 percent chance of survival. (Ex. 8, at 10, 12.)

[19] "Partial-birth abortions" are "known medically as intact dilatation and extraction, or D & X." Julie Rovner, *US Senate Rejects Post-Viability Abortion Ban*, 349 THE LANCET 9064 (May 24, 1997). According to *The Lancet*, "[T]he vast majority of D & X abortions are performed either before the fetus is viable or when viability is extremely doubtful." *Id. The Lancet* is "the United Kingdom's leading medical journal." *LaMontagne v. E.I. Du Pont De Nemours & Co.*, 41 F.3d 846, 850 (2d Cir.1994).

components: (1) deliberate dilation of the cervix, usually over a number of days; (2) intentional conversion of the living fetus to a "footling breech" (feet-first position) using instruments; (3) pulling the living fetus, except the head, which is too large to pass through the cervix, intact from the uterus through the cervix using instruments; and (4) evacuating the contents of the fetal skull (causing brain death but perhaps not cessation of heart function), thereby compressing the skull and allowing the intact but compressed skull to be pulled through the cervix. *WMPC*, 911 F.Supp. at 1066. When these four steps are accomplished, vaginal delivery of a dead but otherwise intact fetus takes place and the abortion is complete. *Id.* Dr. Haskell typically uses this procedure from 20 to 24 weeks. *Id.* at 1065-66.

In contrast to the Haskell procedure, Carhart takes the living fetus "as he finds it." In other words, Carhart performs the same procedure as Dr. Haskell, but he does not convert the fetus to a "footling breach" if it is not naturally in that position.[20] If the living fetus presents "feet first," Carhart extracts the fetus's torso from the uterus and then drains (or crushes) the skull, which is too large to pass through the cervix unless the skull size is reduced. He performs this procedure approximately 10 to

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[20] Sometimes the fetus will present "sideways" (a "transverse lie") in the uterus. When this happens, Carhart grasps whatever portion of the fetus he can in order to turn it so that part of the body will pass through the cervix. He performs this procedure because "you can't bring the fetus out sideways." (Tr. 156:16-157:3.) If he can grasp the fetus "feet first" he will, but Carhart does not "intentionally spend a lot of time doing that." (Tr. 156:25.)

20 times a year. He tries to do the procedure for every patient between the 16th and 20th week of pregnancy. Carhart performs about 190 abortions during this period.

Thus, Carhart's procedure is the same as Dr. Haskell's *if* the fetus presents "feet first." Other doctors also use this variation of the Haskell procedure. *WMPC*, 911 F.Supp. at 1067 n. 20 (Dr. Doe Number Two).

If the fetus does not present "feet first," Carhart performs a D & E procedure, that is, dismemberment of the living fetus by (1) inserting an instrument into the uterus; (2) grasping a part of the fetus, such as a limb; (3) pulling the fetal part through the cervix; and (4) shearing the part from the body by means of traction where the end of the cervix (cervical os) is the leverage point. When the "D & E" procedure is used, the living fetus is removed from the uterus in parts rather than intact.

Furthermore, and again in contrast to Dr. Haskell, Carhart does his variation of the "partial-birth" abortion procedure primarily on living fetuses around the 16th week to the 20th week rather than between the 20th week and the 24th week. Carhart normally does not attempt the D & X procedure before the 16th week because the fetal body tears apart during the process. After about the 20th week, Carhart induces fetal death by injection before removing the fetus from the uterus unless the woman suffers from a seizure disorder or heart disease or is taking medication that contraindicates use of the injection.

To accomplish fetal death, about 48 to 72 hours before removal of the fetal body, Carhart surgically pierces the woman's abdomen and injects the fetus with a

lethal substance intended to stop its heart. Carhart does not induce fetal death before about the 20th week.

We summarize these findings as follows:

1. Carhart does not do abortions on viable fetuses.

2. Carhart is primarily at risk for prosecution between the 16th week and the 20th week when, save for its head, he places a living fetus into the vaginal cavity before reducing its skull because: (a) Carhart does not normally use the D & X procedure before the 16th week since the fetal body tears apart when pulled from the uterus; and (b) after the 20th week Carhart normally kills the fetus by injection before beginning the D & X procedure.

3. Carhart's D & X procedure varies from Dr. Haskell's procedure in two respects: (a) Haskell attempts to manipulate every fetus to obtain a "feet-first" presentation while Carhart will take the fetus "feet first" if doing so is easier; and (b) Carhart normally uses the procedure on living fetuses between about the 16th week and the 20th week, while Haskell uses the procedure between the 20th week and the 24th week.

C. "Facial" Or "As Applied" Challenges

For purposes of his preliminary injunction request, Carhart limited his challenge to how the law is "applied" to him and his patients. The "practical effect of holding a statute unconstitutional as applied is to prevent its future application in a similar context, but not to render it

utterly inoperative. To achieve the latter result, the plaintiff must succeed in challenging the statute 'on its face.' " *Ada v. Guam Soc'y of Obstetricians & Gynecologists*, 506 U.S. 1011, 1012, 113 S.Ct. 633, 633, 121 L.Ed.2d 564 (1992) (Scalia, J., dissenting from denial of certiorari).

This concession occurred during a telephone conference between the undersigned and counsel on July 24, 1997. As a result, we need not decide whether Nebraska's law is facially invalid in " 'a large fraction of the cases in which [the law] is relevant.' " *Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1456 (8th Cir.1995) (quoting *Casey*, 505 U.S. at 895, 112 S.Ct. at 2829-30), *cert. denied sub nom. Janklow v. Planned Parenthood, Sioux Falls Clinic*, ___ U.S. ___, 116 S.Ct. 1582, 134 L.Ed.2d 679 (1996). On the contrary, the inquiry is limited to Carhart and his patients.

If the ban is invalid with regard to Carhart, it is invalid for "a large fraction of the cases in which [the law] is relevant." The law applies to every woman who seeks an abortion from Carhart between the 16th and 20th week of pregnancy; therefore, the ban directly impacts about 190 of the 800 women who seek abortions from him annually.

As long as he limits his challenge to how the law is "applied" to his situation, a favorable ruling for Carhart will not invalidate the Nebraska law generally. In contrast, such a ruling will only preclude enforcement of the Nebraska law against Carhart and his patients (and other similarly situated doctors and their patients). For example, a favorable ruling for Carhart would not preclude enforcement of the ban on post-viability abortions since

Carhart does not perform such abortions and his "as-applied" challenge does not extend to that portion of the law. *Ada*, 506 U.S. at 1012, 113 S.Ct. at 633.

D. Preliminary Injunction Standards

In *Dataphase Systems, Inc. v. C L Systems, Inc.*, 640 F.2d 109, 113 (8th Cir.1981) (en banc), the United States Court of Appeals for the Eighth Circuit required district courts confronted with a request for a preliminary injunction to evaluate (1) the threat of irreparable harm to the movant; (2) the state of the balance of the harm and injury that granting the injunction will inflict on other parties litigant; (3) the probability that the movant will succeed on the merits; and (4) the public interest. "No single factor in itself is dispositive; in each case all the factors must be considered to determine whether on balance they weigh towards granting the injunction." *Calvin Klein Cosmetics Corp. v. Lenox Lab., Inc.*, 815 F.2d 500, 503 (8th Cir.1987).

E. Unnecessary Maternal Medical Risk is an "Undue Burden"

Carhart claims Nebraska's "partial-birth" abortion ban prohibits his female patients from choosing, with his advice, a safe and desired method of terminating pregnancy before viability. Therefore, Carhart argues that the Nebraska law as applied is unconstitutional in that it violates his patients' Fourteenth Amendment Due Process right to choose whether to have an abortion before viability. *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d

147 (1973), *as modified by Casey*, 505 U.S. at 833, 112 S.Ct. at 2796.

After applying and carefully weighing the *Dataphase* factors, we find and conclude that Carhart is entitled to a preliminary injunction. Nebraska's ban on Carhart's "D & X" procedure has the effect of subjecting Carhart's patients to an appreciably greater risk of injury or death than would be the case if these women could rely upon Carhart to perform his variant of the banned procedure on nonviable fetuses when medically advisable.

1. Probability of Success on the Merits

a. The Law

Carhart is likely to succeed on the merits. Nebraska's ban on "partial-birth abortions" requires women who seek abortions on nonviable fetuses to take appreciable medical risks that are not necessary to preserve their lives or health. Nebraska's law thus subordinates maternal life and health to the life and health of a nonviable fetus. As a result, Nebraska's ban imposes a constitutionally unacceptable "undue burden" on Carhart's patients. *Casey*, 505 U.S. at 878, 112 S.Ct. at 2821. Simply put, we cannot constitutionally allow the life or health of a woman to be made subservient to the state's otherwise profound interest in a nonviable fetus.

An abortion law is invalid if it places an "undue burden" in "the path of a woman seeking an abortion before the fetus attains viability." *Id. See also Planned Parenthood, Sioux Falls Clinic*, 63 F.3d at 1463 (applying *Casey*

and holding, among other things, that parental notification provisions of abortion law that did not include bypass options other than bypass options for abused and neglected minors was unconstitutional). An abortion law may create an "undue burden" if it "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Casey*, 505 U.S. at 877, 112 S.Ct. at 2820. In other words, the law may be invalid because (1) the legislature intended to place a substantial obstacle in the path of a woman seeking abortion, or (2) the effect of the law is to place a substantial obstacle in the path of a woman seeking abortion. *Id.*

Of course, not all burdens are "undue." Thus, state regulations "which do no more than create a structural mechanism by which the State, or the parent or guardian of a minor, may express profound respect for the life of the unborn are permitted, if they are not a substantial obstacle to the woman's exercise of the right to choose." *Id.* Likewise, "[r]egulations designed to foster the health of a woman seeking an abortion are valid if they do not constitute an undue burden." *Id.* at 878, 112 S.Ct. at 2821. In short, the "very notion that the State has a substantial interest in potential life leads to the conclusion that not all regulations must be deemed unwarranted." *Id.* at 876, 112 S.Ct. at 2820.

Nevertheless, it is beyond dispute that "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden." *Id.* at 878, 112 S.Ct. at 2821. The Supreme Court and lower federal courts have consistently held that abortion regulations that impose

medically unnecessary health risks on women are invalid. *See, e.g., Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 768, 106 S.Ct. 2169, 2182-83, 90 L.Ed.2d 779 (1986) (state law not susceptible to construction that did not " 'require the mother to bear an increased medical risk in order to save her viable fetus' " was unconstitutional) (citation omitted)[21]; *Colautti*, 439 U.S. at 400, 99 S.Ct. at 688 (state law requiring a doctor to use the technique that provided the best opportunity for the viable fetus to be aborted alive was unconstitutional because it was uncertain whether the law permitted "the physician to consider his duty to the patient to be paramount to his duty to the fetus"); *Planned Parenthood of Mo. v. Danforth*, 428 U.S. 52, 79, 96 S.Ct. 2831, 2845-46, 49 L.Ed.2d 788 (1976) (state law that "forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed" was unconstitutional); *Jane L. v. Bangerter*, 61 F.3d 1493, 1502-1504 (10th Cir.1995) (Utah law which required post-viability abortion to be conducted in a manner that gave the unborn child the best chance of survival unless the method would cause "grave damage to the woman's medical health" impermissibly burdened a woman's right to seek abortion under *Casey* because it required a woman to bear an " 'increased medical risk' " in order to save the life of a viable fetus) (quoting *Thornburgh*, 476 U.S. at 769, 106 S.Ct. at 2183), *rev'd in part on other grounds sub nom. Leavitt v. Jane L.*, ___ U.S. ___, 116 S.Ct. 2068, 135 L.Ed.2d

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[21] *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 106 S.Ct. 2169, 90 L.Ed.2d 779 (1986), *overruled in part on other grounds in Casey*, 505 U.S. at 870, 882, 112 S.Ct. at 2816-17, 2823 (O'Connor, Kennedy, & Souter, JJ.).

443 (1996) (per curiam)[22]; *WMPC*, 911 F.Supp. at 1070 (D & X procedure "appears to pose less risk to maternal health than any other alternative"; therefore, the ban had the "effect of placing a substantial obstacle in the path of women seeking pre-viability abortions" and was "an undue burden and thus unconstitutional under *Casey*").

b. Greater Maternal Medical Risk

Keeping in mind that Carhart normally does the D & X procedure on living fetuses between about the 16th and 20th weeks of pregnancy, Nebraska's ban on "partial-birth" abortions regarding nonviable fetuses has the "effect"[23] of subjecting his patients to an appreciably greater risk of injury or death than would be the case if these women could rely upon Carhart to do his variant of the banned procedure when medically advisable. The result is an "undue burden" under Casey.

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[22] On remand, the Tenth Circuit Court of Appeals reaffirmed its holding that Utah's choice-of-method statute was unconstitutional because " '[b]y requiring a woman to suffer "grave damage" to her, health before her liberty interests predominate, the Utah legislature violated those portions of *Roe* and *Thornburgh* . . . that Casey reaffirmed, and unconstitutionally devalued a woman's privacy rights.' " *Jane L. v. Bangerter*, 102 F.3d 1112, 1118 n. 7 (10th Cir.1996), *cert. denied sub nom. Leavitt v. Jane L.*, ___ U.S. ___, 117 S.Ct. 2453, 138 L.Ed.2d 211 (1997) (quoting Jane L., 61 F.3d at 1504).

[23] We assume, without deciding, that Nebraska's purpose in enacting the ban was constitutional.

(1) Statistically, the D & X Procedure is at Least as Safe as the D & E Procedure and Appreciably Safer than All Other Forms of Abortion

The data suggest that the D & X procedure, a variant of the D & E procedure, is appreciably safer than all other forms of abortion during the relevant gestational time. According to the AMA report, there are four alternative procedures that "can be used to induce abortion" between "the 16th to 24th week of gestation," "includ[ing] dilation and evacuation [D & E] (which may or may not be preceded by induced fetal demise), dilation and extraction (D & X), labor induction, hysterotomy and hysterectomy." (Ex. 7, at 8.) The "D & X" procedure (used by Carhart and others) is "a form of D & E." (*Id.*)

When measured by maternal death, for the period between 13 weeks and plus or minus 21 weeks, the "D & E" procedure is measurably safer than labor induction, hysterotomy, and hysterectomy, the other abortion procedures customarily used during this time. (*Id.* at 10, tbl. 4: Maternal Mortality Rates for Induced Abortion Procedures at 13 Weeks' Gestation or Later, U.S., 1974-1987) (Total: "D & E," 3.7 deaths[24]; Induction, 7.1 deaths; Hysterectomy/Hysterotomy, 51.6 deaths). The same is true for the 16th week to the 20th week. (*Id.*) (16-20 weeks: "D & E," 6.5 deaths; Induction, 7.9 deaths; Hysterectomy/Hysterotomy, 103.4 deaths).

[24] Per 100,000 abortions.

Moreover, the "risk of complications" is as important as the mortality risk. The complication[25] rate for the D & E procedure is only 7 per 1,000 compared to between 21 and 25 per 1,000 for induction procedures, and a much greater risk is associated with other procedures such as hysterectomy. (*Id.*)

According to Dr. Henshaw of the Guttmacher Institute,[26] because the D & X is a variant of the D & E, no separate statistics comparing the D & E with the D & X are available. (Tr. 52, 70, 78-79.) Nevertheless, because "the D & X is one type of D & E," the "only reason to single that [procedure] out for special interest is because it has special political significance." (Tr. 79:4-7.) The difference between the two procedures "isn't really a medical issue, but it is a political issue." (Tr. 79:1-2.) Consequently, we believe the overall mortality and complication rates for the D & X procedure are at least as good as the D & E and much better than other forms of abortion.

[25] A "complication" is defined by the CDC as "major unintended surgery, a hemorrhage requiring a blood transfusion, a hospitalization of 11 days or more, or a temperature of at least 38.0° C (100.4° F) that lasts for 3 or more days." (*Id.* at 10.)

[26] The institute collects abortion data that is relied upon by the CDC. (Tr. 46.)

(2) Medical Evidence Establishes That the D & X Procedure is Appreciably Safer for Women Than the D & E Procedure

The credible medical evidence establishes that the D & X procedure used by Carhart is appreciably. safer than the D & E procedure "may minimize trauma to the woman's uterus, cervix, and other vital organs" because it reduces "uterine or cervical perforation either from instruments used during the D & E, or through piercing by fetal parts." (Ex. 7, at 8.)[27] Moreover, Dr. Hodgson, a very credible board-certified physician who has performed more than 30,000 abortions, delivered at least 5,000 babies, and is a founding fellow of the American College of Obstetricians and Gynecologists, believes the D & X procedure is "an advance in technology" because by removing the fetus intact there is "less instrument

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[27] During examination by defense counsel, Dr. Hodgson was asked whether "the AMA has gone on record . . . as supporting the proposed federal legislation banning partial[-birth] abortion." (Tr. 223:15-18.) Dr. Hodgson replied, "Yes, to my dismay, that's true." (Tr. 223:20.) However, the defendants did not offer that testimony to prove the truth of her statement regarding the AMA's position. (Tr. 224:2-18.) The portion of the AMA report received in evidence does *not* in any way suggest that the D & X procedure should be banned, nor does it suggest that the D & X procedure is outside accepted medical practice. *See also Julie Rovner, AMA Fails to Change Outcome of Long-Running U.S. Abortion Debate,* 349 THE LANCET 9065 (May 31, 1997) (describing differences between the AMA report and a statement issued by the AMA). The political statements of the AMA (or any other professional group) are irrelevant to our decision. We commend counsel for stipulating into evidence portions of the AMA report that contained relevant facts as opposed to political rhetoric.

manipulation" and "of course, the higher your safety." (Tr. 212:4-22.)

Furthermore, Carhart's testimony convinces us that the D & X procedure he uses is appreciably safer than performing a D & E because:

1. Intact removal of the fetus reduces the possibility of complications from the passage of sharp bony fragments through the cervix and is therefore less traumatic to a woman's cervix and uterus. (Tr. 101, 124-25, 131, 158);[28]

2. By removing the fetus intact, as opposed to removing pieces from the uterus as required by the D & E, the D & X procedure reduces the use of instruments in the uterus which in turn lessens the risk of complications from tearing or perforating the uterus with instruments. (Tr. 108, 131, 158, 179-80);

3. By using this procedure, Carhart prevents disseminated intravascular coagulopathy (DIC) and amniotic fluid embolus, both of which are among the most common causes of maternal mortality and complications. (Tr. 101-02, 131);

4. By removing the fetus intact, Carhart reduces the likelihood of retained fetal parts, (Tr. 183), which Dr. Hodgson testified is a "horrible complication." (Tr. 211:21.)

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[28] As the AMA report indicates, by the 16th week of pregnancy the bones of the fetus "are more rigid." (Ex. 7, at 8.)

Carhart's testimony is consistent with testimony received by the court in WMPC, 911 F.Supp. at 1069.[29] In that case, Dr. George Goler, Ohio section chief of the American College of Obstetricians and Gynecologists, testified that he "views [the D & X procedure] as an improvement over the traditional D & E procedure" because it causes "less trauma to the maternal tissues by avoiding the break up of bones, and the possible laceration caused by their raw edges" and because it causes "less blood loss." *Id.* (parentheses omitted). In addition, Dr. Haskell testified that his use of the D & X procedure resulted in no serious complications in approximately 1,000 procedures, while out of approximately 1,000 other procedures where he used the D & E technique, two patients had serious complications. *Id.*

Carhart's testimony is also consistent with the testimony received by the court in *Evans*. *Evans*, No. 97-CV-71246-DT, slip op. at 30-31, ___ F.Supp. at ___ - ___. There the court heard testimony from various doctors, including Dr. Mark Evans (plaintiff), a board-certified obstetrician, gynecologist, clinical geneticist, and vice-chief of obstetrics at a hospital; Dr. Dennis Christensen (plaintiff), a board-certified obstetrician and gynecologist and assistant clinical professor at the University of Wisconsin (where he teaches abortion procedures); Dr. Carolyn Westoff (plaintiff's expert), a board-certified

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[29] The court has summarized facts found in other cases for the purpose of showing that the facts found in this case are consistent with the evidence presented in other cases. We have not attributed the evidence presented in other cases to the plaintiff for the purpose of determining whether he has satisfied the burden of proof.

obstetrician, gynecologist, and epidemiologist; Dr. Curtis Cook (defense expert), a board-certified obstetrician and gynecologist; and Dr. Timothy Johnson (court-appointed expert), a board-certified obstetrician and gynecologist with a sub-certification in the area of maternal-fetal medicine. *Id.*, slip op. at 5-13, ___ F.Supp. at ___ - ___.

"Comparing a conventional D & E to an intact D & E, Drs. Westoff, Doe, Evans, Christensen, Johnson and Cook all agree that the intact procedures reduce risks associated with conventional D & Es," *id.* at 30, at ___, for four reasons:

1. "The intact procedure reduces the risk of uterine perforation and cervical lacerations because removing the fetus intact, rather than in pieces, entails less instrumentation of the uterus and minimizes the passage of bony fetal fragments through the cervix and vagina."

2. "Removing the fetus intact also reduces the risk of a free-floating head, an uncommon, but significant complication of a conventional D & E."

3. "And," Dr. Westoff testified, "[R]emoving the fetus intact is often quicker than dismembering it, the woman has less operative time, which means less risk of hemorrhage, less total bleeding and less risk of infection."

4. "Further," Dr. Evans opined, "[T]he intact procedure would be superior to a conventional dismemberment procedure for a

> woman for whom induction is contraindicated and who has a presumed fetal abnormality for which a fetal autopsy would be very instructive."

Id. at 30-31, at ___ - ___.

(3) Inducing Fetal Death by Injection has Appreciable Maternal Risks But No Maternal Benefits and is Not Always Possible

While there is no maternal health benefit in attempting to kill a fetus in utero by injection before the 20th week of pregnancy, there are appreciable maternal health risks in attempting such a procedure. Consequently, if Carhart has to ensure fetal death by injection before the 20th week in order to do a D & X procedure, he must subject his patients to an appreciable risk of harm for no maternal benefit or else perform more risky procedures such as the D & E.

The reason doctors use an injection to kill the fetus in utero after the 20th week is that the size of the fetus makes it difficult to extract from the uterus. (Tr. 120, 178-79.)[30] If they kill the fetus and wait two to three days, the body of the fetus shrinks and becomes less rigid and more malleable. (Tr. 120.) Thus, the medical benefit to the mother of killing the fetus by injection after 20 weeks is reduced fetal size and increased malleability that results

[30] According to a book published by the State of Nebraska, at 21 to 22 weeks the fetus is 8W inches long and weighs up to a pound. (Ex. 8, at 11.) At 23 to 24 weeks, the fetus is approximately 9 inches long and weighs up to 1 pound 6 ounces. (*Id.* at 12.)

in less difficulty (including less dilation of the cervix) removing the fetus from the uterus. (*Id.*) However, before the 20th week, when the fetus is smaller, there is less need to obtain shrinkage and malleability, and shrinkage and malleability are, in any event, insignificant. (*Id.* at 120-21.)

On the other hand, killing the fetus by injection requires a surgical procedure that carries risks to maternal life and health. (Tr. 121-22; 186-88.) To kill a fetus using this method, a needle is inserted through the midline of the woman's abdomen.[31] (Tr. 186.) The doctor then attempts to guide the needle to the fetal heart by ultrasound. (*Id.*) The doctor then tries to pierce the fetal heart or surrounding amniotic sac with the needle to inject a solution that will stop the fetal heart. (*Id.* at 186-87.) During this procedure, the doctor must avoid the maternal bowel and uterine wall not only to avoid damage to those structures, but also to avoid injecting a potentially dangerous drug into the maternal bloodstream. (Tr. 121-22; 188.) Such a procedure is particularly difficult when the fetus is less than 20 weeks because "you have a much smaller target and you have more of a chance of getting medication into the maternal circulation than you do into the fetal circulation." (Tr. 121:25-122:3.)[32]

[31] This procedure is similar to diagnostic amniocentesis, where fluid is withdrawn from the amniotic sac. (Tr. 243-244.) Unlike amniocentesis, however, the use of an injection to cause fetal death normally requires injecting fluid into the fetus's heart. (*Id.*) Since the fluid is dangerous to maternal health, the medical risks of fetal injection are greater.

[32] The State of Nebraska believes that at 18 weeks the fetus weighs about 7 ounces, is about 614 inches long, and has a head

The defense expert, Dr. Riegel, corroborated some of Carhart's testimony about the advisability of using fetal injections to cause death. For example, Dr. Riegel testified there was no maternal medical advantage to injecting a substance into the fetus while it is in the uterus in order to kill the fetus prior to removing it. (Tr. 250.) Moreover, Dr. Riegel testified that physicians generally restrict themselves "to 19 weeks and up . . . if people are going to use that particular route to stop the heart of a fetus." (Tr. 244:24-255:1.)[33] Still further, in the part of Texas where Dr. Riegel practices, only "high risk obstetricians" conduct the related but less risky amniocentesis procedure between 13 and 18 weeks. (Tr. 285.)

In addition, some women cannot be given an injection to kill the fetus under any circumstances. For example, injecting medication to stop the fetal heart when the mother suffers from a heart condition is inappropriate. (Tr. 122-23.) Consequently, if we required that Carhart use an injection to kill the fetus when not medically advisable in order to do a D & X procedure (whether before or after 20 weeks), either his patients would be subjected to the unnecessary risk of the injection or Carhart would have to perform more risky procedures such as the D & E.

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about one-third its size. (Ex. 8, at 9.) At 19 to 20 weeks, the fetus weighs 7 to 11 ounces and is 6 1/4 to 7 1/2 inches long. (*Id.* at 10.) According to the State of Nebraska, the fetus doubles its weight between the 19th and 22nd weeks. (*Id.* at 10-11.)

[33] The AMA report indicates fetal death by injection takes place "after 20 weeks." (Ex. 7, at 8.)

(4) There is No Maternal Health Benefit in Forcing the Woman to Wait Until After the 20th Week So That the Fetus Can Be Killed by Injection, and There is Appreciable Risk to Maternal Health in Doing So

Assuming the patient does not have a heart condition or similar problem precluding fetal injection, in order to do the D & X procedure with a dead fetus, Carhart could force a woman to wait for an abortion until after the 20th week and then undergo the injection procedure to kill the fetus in utero. There is no maternal medical benefit to this strategy, and there is appreciable risk in doing so.

For example, Dr. Henshaw testified that "the rate of complications increases by about 20% for each additional week of gestation from about eight weeks on." (Tr. 59:12-14.) In this vein, the AMA report confirms that the "risk of maternal death increases with gestational age." (Ex. 7, at 9.) In fact, before 21 weeks the risk of maternal death due to abortion is measurably less than the risk of maternal death from childbirth,[34] but by 21 weeks the risks are similar. (*Id.*)

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[34] Between 16 and 20 weeks the risk of maternal death from abortion is 1 in 17,000 procedures, whereas the risk of death during childbirth is 1 in 13,000 deliveries. (*Id.*)

(5) Cutting the Umbilical Cord and Waiting for the Fetus to Die before Completing the D & X Procedure Carries Appreciable Maternal Risks and No Maternal Benefits and Is Not Always Possible

Although Carhart tries to cut the umbilical cord during the D & X procedure, with the result that the fetus eventually dies, he does not wait the 6 to 10 minutes it takes for the fetus to die before completing the D & X procedure because doing so increases maternal blood loss. (Tr. 190.) There is no maternal benefit in waiting for the fetus to die in this circumstance, and there is an appreciable risk to maternal life and health in doing so. If forced to cut the cord and wait for the fetus to die, Carhart must either abandon the D & X procedure for the more risky D & E or subject his patient to unnecessary blood loss. Moreover, there are times when Carhart cannot reach the cord to cut it before vaginal delivery of the fetal body. (Tr. 111, 190.) In this circumstance, he would be forced to use the more risky D & E procedure or violate the law by completing the D & X procedure.

c. Defendants' Arguments are Not Persuasive

The defendants assert various arguments to convince us that maternal risk is irrelevant, nonexistent, or insignificant. These arguments merit a brief response. Moreover, it is helpful to state the one defense not asserted by the defendants.

The defendants *do not* argue that the "medical exception" to Nebraska's ban saves the statute from Carhart's

challenge. Given the plain meaning of the medical exception, they have no basis for such an argument.

The law prohibits Carhart from performing his variant of the D & X procedure "unless such procedure is necessary to save the life of the mother whose life is endangered by physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." LB 23 § 3(1). This exception does not apply to Carhart's patients because:

1. Risks to maternal health are not considered;
2. Despite the fact that abortions are safer than childbirth until the 21st week, mortality risks associated with one abortion procedure being more dangerous than another are not considered since such risks do not arise out of a "physical disorder, physical illness, or physical injury, including . . . pregnancy itself."

As the defendants do not contend that the medical exception protects Carhart and saves the statute, we need not pursue the issue any further.

The defendants do argue that *Roe* and *Casey* do not apply to Nebraska's law because "the Supreme Court has never recognized a constitutional right to kill a *partially born human being*." (Defs.' Br. Opp'n Pl.'s Mot. Prelim. Mot. [*sic*] at 3 (emphasis added).) We reject this argument because there is no precedent for it.[35]

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[35] There is also no evidence to support this contention. For example, the evidence does not show that placement of the fetus

Roe and *Casey* categorized fetuses as viable or not viable. No case with which we are familiar uses the "partially born human being" category as a construct for constitutional analysis. It is our job to fairly apply the precedents of the Supreme Court whether we agree with them or not. *See, e.g., Dronenburg v. Zech*, 741 F.2d 1388, 1396 n. 5 (D.C.Cir.1984) (Bork, J.). Accordingly, we decline the defendants' invitation to ignore *Roe* and *Casey*.

Next the defendants argue that there is no risk to maternal health or life if Carhart is precluded from using his variant of the D & X procedure. Using "statistical significance" as their point of attack, defendants argue that no "statistically significant" difference in mortality rates exists for the D & E procedure (which, they agree, includes the D & X procedure) compared to the induction procedure. (Defs.' Post-Hr'g Br. Opp'n Pl.'s Mot. Prelim. Inj. at 10-12.)[36] Consequently, the defendants argue that

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partially in the uterus and partially in the vaginal cavity is the medical equivalent of birth. *See* STEDMAN'S MEDICAL DICTIONARY at 175 (defining "birth" as "the complete expulsion or extraction from its mother of a fetus"). Nor does the evidence show that such placement makes a nonviable fetus viable. *Id.* at 1551 (defining "viable" as "denoting a fetus sufficiently developed to live outside of the uterus").

[36] Using one sentence from the AMA report, (Ex. 7, at 9:34), regarding the statistical significance of the difference between two numbers in one data set, the defendants compute a ratio for the difference between these two numbers. Then the defendants take that ratio and apply it to other numbers in other data sets in an effort to inferentially derive statistical significance. The defendants do not attempt to apply any of the conventional tests for statistical significance.

Carhart's patients can always use the equally safe induction method of abortion as an alternative to the D & X procedure.[37]

Among other reasons, we reject this argument because:

1. The statistical analysis in the defendants' brief was not presented as evidence through the testimony of a reputable analyst such as Dr. Henshaw;

2 The statistical analysis in the defendants' brief is flawed because it does not employ accepted methodology for determining statistical significance;

3 The statistical-significance argument is limited to mortality rates and ignores complication rates, *see, e.g., Evans*, No. 97-CV-71246-DT, slip op. at 28, ___ F.Supp. at ___ (Dr. Westoff explained that "inductions have higher rates of infection, bleeding, cervical

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[37] Even if this were true (and it is not), "induction" requires the patient to undergo labor in a hospital. Such a requirement, entailing as it does significant emotional and physical pain and economic cost, would constitute an "undue burden" under *Casey* because it would have the effect of placing a substantial obstacle in the path of a woman trying to decide whether to abort a nonviable fetus. Furthermore, since only three Nebraska hospitals permit abortions, and at least one of them appears to limit "elective" abortions, such a procedure is not available to most Nebraska women. As the evidence shows, out of 5,214 abortions conducted in Nebraska in 1996, not one was conducted by induction. The dearth of hospitals willing or able to do induction abortions would also create an "undue burden."

lacerations, amniotic fluid embolus and disseminated intravascular coagulation ('DIC')");

4 "Statistical significance" is not normally used by doctors to express risk assessments for individual patients (Ex. 7, at 10 (tbl. 4 pertaining to maternal mortality and text pertaining to maternal morbidity));

5 The statistical-significance argument ignores the testimony of doctors like Carhart, Hodgson, Goler (*WMPC*), Haskell (*WMPC*), Westoff (*Evans*), Evans (*Evans*), Christensen (*Evans*), Johnson (*Evans*), and Cook (*Evans*) that the D & X is safer than the D & E; thus, even if the D & E procedure and the induction method were equally safe, the D & X appears to be safer than either of them;

6 The statistical-significance argument ignores the AMA report's recognition that the D & X "procedure may minimize trauma to the woman's uterus, cervix, and other vital organs," (Ex. 7, at 8), and that "maternal mortality during second-trimester abortions is lower[38] for dilation and evacuation procedures than for labor induction methods." (Ex. 7, at 11);

7 The statistical-significance argument ignores the fact that inductions are contraindicated for certain women because of medical conditions like hypertension, heart disease, or diabetes. (Tr. 125:6-126:1.) *See also Evans*, No.

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[38] This is true before "20 weeks' gestation and beyond." *Id.* As noted earlier, Carhart normally performs his variant of the D & X procedure between 16 and 20 weeks.

97-CV-71246-DT, slip op. at 28-29, ___ F.Supp. at ___-___ (Drs. Johnson, Evans, and Westoff testified that inductions are either "absolutely" or "relatively" contraindicated for (a) women with a prior classical Caesarean scar; (b) women with a prior hysterotomy; (c) women with renal disease; (d) women with cardiovascular disease; and (e) cases of fetal abnormality where the size of the fetal skull "can increase the risk of vaginal delivery").

In a related argument, the defendants point to Dr. Riegel's testimony suggesting the D & X procedure is dangerous to maternal health because it involves the use of sharp instruments to pierce the fetal skull and because the procedure is "blind." Among other reasons, we reject this argument because Dr. Riegel is not competent to testify about procedures he has neither observed nor performed.

Finally, the defendants argue that a law denying a woman a "marginally 'safer' " abortion is nevertheless constitutional because the increased risk must pose "a significant threat to the mother" in order to be unconstitutional. (Defs.' Post-Hr'g Br. Opp'n Pl.'s Mot. Prelim. Inj. at 4-9.) We reject this argument for two reasons.

Initially, women deciding whether to seek abortions are confronted with a substantial obstacle to choosing abortion (undue burden) if they are required by the state to accept an increased risk of death or serious injury which, though small, is nevertheless real. The cases we have cited in part II.E.1.a. stand squarely for this proposition.

Moreover, we reject the premise of the defendants' argument; that is, we are unwilling to find and conclude on the record before us that the increased risk to maternal life and health is "small" or "marginal." In particular we point out that for women who die or suffer serious complications because they cannot have the safest available procedure to abort their nonviable fetuses, the increased risk cannot honestly be considered insignificant.

2. Irreparable Harm to Plaintiff

Plaintiff and his patients will suffer irreparable injury absent an injunction. It is well established that a statute that "interfere[s] with the exercise of [abortion providers'] constitutional rights and the rights of [their] patients supports a finding of irreparable injury." *Planned Parenthood of Minn. Inc. v. Citizens for Community Action*, 558 F.2d 861, 867 (8th Cir.1977). This is particularly true where, as here, the statute imposes appreciable risks on the lives and health of a doctor's patients. Death is irreparable.

3. Harm to Defendants

We do not underestimate Nebraska's profound interest in nonviable fetuses. However, any reasonable analysis of the balance of harm to the defendants and the plaintiff and his patients favors the plaintiff and his patients. Nonviable fetal life cannot constitutionally be considered superior to maternal life or health. More

practically, one defense attorney candidly[39] acknowledged that "we know there are a lot of problems," including "great proof problems," with enforcing the statute as written. (Tr. 43:4-11.) These statements amount to a concession that the defendants will suffer little or no injury if the statute is preliminarily enjoined.

4. Public Interest

We recognize that the Nebraska legislature passed LB 23 with near unanimity. We are also aware that a federal court must proceed cautiously when asked to interfere with the democratic processes of state government. Nevertheless, the public interest would not be served by failing to enjoin a legislative scheme such as this that carries with it real risks to maternal health and safety. We are not the only court to arrive at the conclusion that injunctive relief is justified in cases dealing with "partial-birth" abortion statutes. *See, e.g., Evans*, No. 97-CV-71246-DT, ___ F.Supp. ___ (preliminary and permanent injunction); *Little Rock Family Planning Servs. v. Jegley*, No. LR-C-97-581 (E.D.Ark. July 31, 1997) (temporary restraining order); *Planned Parenthood of S. Ariz., Inc. v. Woods*, No. CIV 97-385-TUC-RMB (D.Ariz. July 18, 1997) (same); *Causeway Med. Suite v. Foster*, No. 97-2211 (E.D.La. July 14, 1997) (same); *Rhode Island Med. Soc'y v. Pine*, No. 97-416L (D.R.I. July 11, 1997) (same); *Midtown Hosp. v. Miller*, No. 1:97-CV-1786-JOF (N.D. Ga. June 27, 1997) (same); *WMPC*, 911 F.Supp. at 1094 (preliminary injunction).

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[39] We compliment counsel for her candor.

III. CONCLUSION

We know three things with certainty. We know the turmoil the abortion controversy causes the citizens of Nebraska. We also know as unelected judges that we are not "free to invalidate state policy choices with which we disagree." *Casey*, 505 U.S. at 849, 112 S.Ct. at 2806. Finally, and despite the first two points, we know we are not free to "shrink from the duties of our office." *Id*. To this end, we have ruled as we believe the law, interpreted by the Supreme Court, requires – nothing less and nothing more.

IT IS ORDERED that:

(1) Plaintiff's request for a preliminary injunction is granted as provided herein;

(2) Defendants, and each of them, including their agents, servants, and employees, are preliminarily enjoined from enforcing LB 23 against Plaintiff regarding his performance of D & X abortions on nonviable fetuses;

(3) The court determines under Federal Rule of Civil Procedure 65 that a bond in the amount of $105.00 is sufficient and directs Plaintiff to post such a bond.

(3)

No. 99-830

Supreme Court, U.S.
FILED
DEC 14 1999
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska; GINA DUNNING, Director of Regulation and Licensure of the Nebraska Department of Health and Human Services; and CHARLES ANDREWS, M.D., Chief Medical Officer of the State of Nebraska,

Petitioners,

—v.—

LEROY H. CARHART, M.D.,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the Nebraska partial-birth abortion statute is unconstitutional under this Court's decisions in *Roe v. Wade*, 410 U.S. 113 (1973), *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), *Thornburgh v. ACOG*, 476 U.S. 747 (1986), and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), because it bans a broad range of abortion procedures, including the safest methods of second-trimester abortion available in Nebraska, without regard to fetal viability and without any exception for the woman's health?

2. Whether the court of appeals properly declined to narrow the scope of the Nebraska partial-birth abortion statute because doing so would have required the court to rewrite the law and because such a narrowing construction would not cure its constitutional deficiencies?

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Respondent LeRoy Carhart, M.D., respectfully submits the following response to the petition for a writ of certiorari filed by the Attorney General of Nebraska ("the State").

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit is reported at 192 F.3d 1142 (8th Cir. 1999).

COUNTERSTATEMENT OF THE CASE

The State fails utterly to summarize the factual findings of the district court, instead preferring to rely largely upon hearsay contained in Congressional documents not in the record. This is because, quite simply, the State's arguments for reviewing the Nebraska partial-birth abortion ban statute ("the Act") are meritless, and the State can find no refuge in the facts of this case. The findings of the district court are nevertheless crucial to understanding the scope of the Act and the impact it would have on women's right to privacy in Nebraska, because those findings demonstrate that Dr. Carhart performs most second-trimester abortions in a sequence of steps that fits the Act's language precisely.

The district court found, and the State does not contest, that the phrase "partial-birth abortion" is not a medical term. S-5.[1] Indeed, for purposes of this case, it is a legal term defined in the Act. The State seeks, by *ipse dixit*, to equate the Act's definition of partial-birth abortion with one very specific abortion technique described by the district court.[2]

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[1] The supplemental appendix to the petition, containing the opinions of the district court, is cited herein as "S-[page number]"; the appendix bound with the petition is cited as "App. [page number]; and the Petition itself is cited as "Pet. [page number]." The appendix to this Brief is cited as "A-[page number]."

[2] The district court describes several D&E variants, all of which have been denominated "D&X" or "intact D&E" procedures. *See* S-14-18, 22-24. Yet another definition of D&X has been given by the federal district court in Wisconsin. *Planned Parenthood v. Doyle*, 44 F. Supp. 2d 975,

See Pet. at 3-4. But the uncontested facts found by the district court demand rejection of this proposed equation,[3] and instead fully support the conclusion of the court below that the Act "covers a great deal more," App. 4, than the sequence of steps put forward in the Petition. *See also* S-75 ("If the Nebraska legislature meant to ban only the D&X procedure, it did not accomplish its purpose.").[4]

The district court's opinion describes several methods of abortion in detail, namely suction curettage (also called vacuum aspiration); dilation and evacuation (D&E), as well

985 (W.D. Wis. 1999) (finding that abortion in which the physician suctions the cranial contents, crushes the skull or cuts the umbilical cord after "partially vaginally delivering a living child" constitutes a D&X prohibited by Wisconsin's law). It is completely unclear which of these possible variants of D&X the State seeks to equate with "partial-birth abortion."

[3] The State deceptively asserts that the district court "described the partial-birth abortion/D&X procedure as follows," Pet. 3, and then proceeds to quote a portion of the district court opinion which describes the "Intact Dilation and Evacuation (Intact D&E or D&X)," *see* S-14 (heading), S-33 (quoted section), not some amalgam of partial-birth abortion *and* D&X. The district court was quite clear that these two terms are distinct: one is a recognized medical procedure, *see* S-65-70, and the other is a broad term employed by the Act. Neither the State's fast and loose sleight of hand with the district court's opinion, however, nor its repeated use of the slash between the terms "partial-birth abortion" and "D&X," can render the two terms equivalent or change the plain language of the Act.

[4] The legislative history of the Act demonstrates that its sponsor, Senator Maurstad, faithfully tracked the language of similar pending federal legislation, amending the Nebraska bill only when they received word that the federal bill was amended. *See* Transcript of Legislative Debate at 6413-14 (Exh. 30) (May 12, 1997); 6796 (May 14, 1997); 7759-62 (May 20, 1997). But the sponsors of federal partial-birth abortion ban bill frankly acknowledged that its was not intended to ban one narrowly defined abortion method, but *any* method of abortion in which the fetus "was partially delivered and then killed -- no matter what the abortionist decides to call his particular technique." A-1 ("Dear Colleague" letter of U.S. Rep. Canady) (Exh. 31).

as one subset of the D&E called "intact dilation and evacuation" ("intact D&E") or "dilation and extraction" (D&X); labor induction; and the two non-vaginal types of abortion, hysterotomy and hysterectomy. *See* S-7-26. Its findings are based both on the testimony presented[5] as well as on two documentary exhibits, one an excerpt of a report of the American Medical Association (AMA), and the other a statement of policy of the American College of Obstetricians & Gynecologists (ACOG).[6]

As is relevant to the opinion of the court below, Respondent Carhart's surgical D&E method would violate the Act -- as would other techniques.[7] Consistent with the explanation of the D&E method provided by the AMA, in

[5] The district court found one of plaintiffs' experts, Dr. Phillip Stubblefield, "particularly persuasive," S-45, and summarized at length his description of various abortion procedures. *See* S-26-37. This testimony included opinions about how new, safer surgical abortion methods evolve. S-34. The State's lead expert, Dr. Boehm, also testified about how over time abortion techniques have become better with a lower "incidence of problems." S-43. This testimony is consistent with this Court's findings in *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 434-39 (1983), that the evolution of the D&E method rendered a second-trimester abortion hospitalization requirement, which was valid at the time of *Roe v. Wade*, 410 U.S. 113 (1973), invalid because such a requirement no longer promoted maternal health.

[6] The parties stipulated to the admissibility of all documents received into evidence by the district court, including these two. *See* S-6-7.

[7] In a companion case, the court below affirmed the finding of the federal district court in Iowa that Iowa's statute, virtually indistinguishable from the Act, could prohibit some first-trimester abortion suction curettage procedures, as well as some less common "combination" abortion techniques. *Planned Parenthood v. Miller*, No. 99-1372, 1999 WL 753770 at *2 (8th Cir. Sept. 24, 1999). The conflicting decision of the Seventh Circuit in *Hope Clinic v. Ryan*, Nos. 98-1726, 99-2528 & 99-2533, 1999 WL 974098 (7th Cir. Oct. 26, 1999), thus mischaracterizes the Eighth Circuit's opinions in the three cases it decided as reaching the decision that the statutes it reviewed were unconstitutional "only after first concluding that all three statutes forbid the D&E procedure." App. 32.

performing a D&E, Dr. Carhart uses ultrasound "to observe the fetus and the surrounding area," then uses "vacuum aspiration or forceps to rupture the membranes," and then "grasp[s] a portion of the fetus in order to bring it out of the uterus with long-handled forceps." S-11. Specifically, "he inserts an instrument inside the uterus, grabs a portion of the fetus, pulls it through the cervical os, and dismembers various fetal parts by the traction created between the instrument and the cervical os. The tearing of fetal parts from the fetal body is accomplished by means of traction at the cervical os." S-12 (citations omitted). Moreover, "[t]he surgeon deliberately intends that all of these events occur in order to perform the D&E, a procedure the surgeon knows and deliberately intends will kill the nonviable living fetus." S-79.

Thus, in performing a D&E in the manner recognized by experts and the AMA, Dr. Carhart satisfies each of the elements in the Act. He "deliberately and intentionally deliver[s] into the vagina a living unborn child, or a substantial portion thereof";[8] he does so "for the purpose of performing a procedure" he "knows will kill the unborn child and does kill the unborn child." *See* Pet. 2 (quoting the Act).

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[8] The district court held that the phrase "substantial portion" was void for vagueness, S-86-87, a holding not reached by the court of appeals. The court of appeals, instead, held that "if 'substantial portion' means an arm or a leg -- and surely it must," App. 16, the Act bans D&E, for once a physician draws a fetal limb out of the uterus (i.e., past the cervical os) in a D&E, she has deliberately and intentionally delivered a "substantial portion" of a living fetus into the vagina. The State does not question the conclusion of the court below that "substantial portion," whatever its boundaries may be, encompasses fetal limbs. Indeed, the sponsor of the Act in the Nebraska legislature opined that "substantial portion" meant "more than a little bit," or "[e]nough that would allow for the procedure to end up with the killing of the unborn child." *See* S-85; *see also* Transcript of Legislative Debate (Exh. 30) at 6440 ("[t]here are many, many definitions of many examples that could fit into the definition of 'partially'") (Maurstad).

He then completes the delivery of the "unborn child" by removing remaining fetal tissue, including placental tissue.

To be sure, when Dr. Carhart succeeds in performing the D&X-type variation of the D&E[9] in order to provide the safest care for some women, *see* n.10 *infra*, he also meets the elements of the Act. In such a procedure, he draws the fetus out of the uterus up to the head and then compresses the fetal head either by crushing it or by removing the cranial contents using suction. *See* S-17. Dr. Carhart uses the D&X-type technique "[i]n an effort to minimize perforation of the uterus or cervix by instruments used during a D&E or from piercing caused by fetal parts." *See* S-14; *see also* S-20 ("Carhart's intent to remove the fetus intact for any abortion performed past 15 weeks' gestation is aimed at reducing the chances of maternal complications or death."). Even the State's chief expert, Dr. Boehm, agreed that intact removal of a fetus during a D&E may have advantages for the woman. S-42. Thus, the district court found after hearing evidence on the preliminary injunction that "[s]tatistically, the D&X procedure is at least as safe as the D&E procedure and appreciably safer than all other forms of abortion," S-62, and, specifically, that "the variant of the D&X procedure used by Carhart is appreciably safer than the D&E procedure," S-62-63, for several reasons.[10] Indeed, after giving the State a full

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[9] The district court found that Dr. Carhart, "the only abortion provider in Nebraska who performs elective abortions past 16 weeks' gestation," S-6, "intends and prefers to remove the fetus using the intact D&E procedure," S-15, although only after the 18th week does the fetus come out intact. *Id.* Thus, in most later second-trimester abortions, Dr. Carhart attempts to perform a D&X-type procedure, though he may not always succeed.

[10] Specifically, the district court reiterated its finding that Dr. Carhart's variant of the D&X was safer than D&E because: "(a) it reduces instrumentation in the uterus that can cause damage to the uterus and cervix; (b) it reduces uterine or cervical perforation from bony fragments; (c) it prevents disseminated intravascular coagulopathy (DIC) and amniotic fluid embolus (among the most common causes of maternal mortality and complications); (d) it reduces the likelihood of retained

opportunity to present additional evidence at trial, the district court remained firm in its "decision that Nebraska's law endangers women by prohibiting Dr. Carhart from performing his version of the D&X procedure." S-64.[11]

In the face of this undisputed evidence that most abortions performed by Dr. Carhart after 15 weeks' gestation are prohibited by the Act's plain language, the State suggests, without citation, that it has disavowed application of the Act to D&E abortions. *See* Pet. 6. This is a misleading characterization of the State's position in this litigation. In fact, the State has only asserted that the Act does not apply to a D&E abortion in which the fetus is dismembered *in utero*. *See* Statements of State's counsel at oral argument before court of appeals, A-4 ("the dismemberment happens before the severed part enters the vaginal cavity"); A-5 ("Yes, but it's still attached, there's been no dismemberment in the vagina it takes place in the uterus and then the dismembered

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fetal parts (a 'horrible complication'); (e) it reduces the risk of 'free floating head,' an uncommon but significant complication; (f) because the D&X is less time consuming than dismembering the fetus, the woman has less operative time, which means less hemorrhage, less total bleeding and less risk of infection when the procedure is used." S-63. *See also* S-71 ("the evidence is both clear and convincing that Carhart's D&X procedure is superior to, and safer than, the D&E and other abortion procedures used during the relevant gestational period"); S-19-22 (explaining these findings in detail). These factual findings (indeed, all the district court's factual findings) were held to be "not clearly erroneous" by the court of appeals, App. 7, and the State does not claim otherwise in its Petition.

[11] Clearly, by prohibiting D&E abortions, which the undisputed evidence shows to be (statistically) the safest method of abortion through 20 weeks of pregnancy, *see* S-46 (summarizing statistical evidence from AMA), the Act endangers women's health. But even if the Act only prohibits D&X-type D&E abortions, it endangers women's health because the district court found the D&X variant used by Dr. Carhart "appreciably safer" than other D&E abortions. S-62; *see also* n.10 *supra*.

part is then passed through the vaginal cavity.").[12] But such a D&E would be less safe for women and is not deliberately performed by Dr. Carhart or by other physicians. *See* S-29 ("Due to the risk of uterine tearing and perforation, dismembering a fetus in utero is 'not done.'"). As the record establishes, in a D&E abortion, dismemberment occurs only *after* the intact fetus has been drawn partway into the vagina. S-12-13 Only by redefining D&E abortions to mean something (*in utero* dismemberment) that no physician ever sets out to do is the State able to say that the Act does not apply to D&E. Moreover, the State has (at times) described the Act as prohibiting *any* abortion involving "the intentional 1) partial delivery of a living fetus vaginally, 2) killing the fetus and 3) completing the delivery." Brief of State Appellants, *Carhart v. Stenberg*, Nos. 98-3245, 98-3300 (8th Cir.), at 66-67. Under this statement, the Act prohibits many more abortions than the single technique described on pages 3-4 of the Petition. *See* cases cited at n.13 *infra*.

REASONS TO DENY THE WRIT OR, IN THE ALTERNATIVE, FOR SUMMARY AFFIRMANCE

The State correctly points out that the unanimous decision of the court below is in conflict with a sharply divided decision of the Seventh Circuit, namely *Hope Clinic v. Ryan*, Nos. 98-1726, 99-2528 & 99-2533, 1999 WL 974098 (7th Cir. Oct. 26, 1999).[13] The State, however,

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[12] No official transcript of the recording of the oral argument before the court below is available. However, the passage excerpted above is transcribed in the Appendix to this Brief. A copy of the audio recording has been lodged with the Clerk.

[13] The State fails to tell this Court, however, that the decision of the court below is consistent with *every other* lower court decision addressing a statute banning partial-birth abortion, including, notably, the decisions of six federal district courts (in the First, Third, Fourth, Sixth, Eighth and Ninth Circuits) that entered permanent injunctions against statutes that are virtually identical, word for word, with the Act. *Planned Parenthood v. Miller*, 30 F. Supp. 2d 1157, 1166 (S.D. Iowa 1998) (permanent

mischaracterizes the important federal question raised by this conflict, pointing instead to a conflict in the "reading" of similar state statutes. A mere conflict in the reading of two similarly, but not identically, worded state statutes is not an "important matter" within the meaning of Rule 10(a) of this Court. The remaining questions presented in the Petition are either not squarely raised in this case (*viz.*, "[w]hether a living human being delivered from its mother's body up to its head is a person for purposes of the Fourteenth Amendment," Pet. at i),[14] or seek plenary review of an entire body of this

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injunction against statute virtually identical to the Act based in part on finding that statute prohibits D&E abortions), *aff'd*, No. 99-1372SI, 1999 WL 753770 (8th Cir. Sept. 24, 1999); *Planned Parenthood v. Verniero*, 41 F. Supp. 2d 478 (D.N.J. 1998) (permanent injunction against statute virtually identical to the Act based in part on finding that statute prohibits D&E abortions), *appeal pending*, No. 99-5042 (3d Cir. argued Nov. 19, 1999); *Eubanks v. Stengel*, 28 F. Supp. 2d 1024 (W.D. Ky. 1998) (permanent injunction against statute virtually identical to the Act based in part on finding that statute prohibits D&E abortions), *appeal pending*, No. 98-6671 (6th Cir. argued Dec. 15, 1999); *Richmond Med. Ctr. for Women v. Gilmore*, 55 F. Supp. 2d 441 (E.D. Va. 1999) (permanent injunction against statute virtually identical to the Act based in part on finding that statute prohibits D&E abortions), *stayed pending appeal without opinion*, No. 99-2000 (4th Cir. Sept. 14, 1999); *Rhode Island Med. Soc'y v. Whitehouse*, 66 F. Supp. 2d 288 (D.R.I. 1999) (permanent injunction against statute virtually identical to the Act based in part on finding that statute prohibits D&E abortions), *appeal stayed*, No. 99-2095 (1st Cir. Nov. 22, 1999); *Weyhrich v. Lance*, No. CV98-0117-S-BLW (D. Idaho Oct. 12, 1999). *See also Little Rock Family Planning Services v. Jegley*, No. LR-C-97-581 (E.D. Ark. Nov. 13, 1998), *aff'd*, 192 F.3d 794 (8th Cir. 1999); *Causeway Medical Suite v. Foster*, 43 F. Supp. 2d 604, 619 (E.D. La. 1999), *appeal docketed*, No. 99-30324 (5th Cir. Apr. 5, 1999); *A Choice for Women v. Butterworth*, 54 F. Supp. 2d 1148 (S.D. Fla. 1998), *appeal dismissed*, No. 99-4002 (11th Cir. Mar. 2, 1999); *Planned Parenthood v. Woods*, 982 F. Supp. 1369 (D. Ariz. 1997), *appeal dismissed*, No. 97-17377 (9th Cir. Feb. 26, 1999); *Evans v. Kelley*, 977 F. Supp. 1283 (E.D. Mich. 1997).

[14] Under no plausible construction of the Act does it prohibit only conduct directed at a "living human being delivered from its mother's body up to its head," nor does the State even bother to explain how such a construction is even possible. Instead, it applies to conduct directed at

Court's precedents (*viz.*, "[w]hether . . . the Court should now recognize that abortion is more properly a public policy legislative matter than a constitutional issue for judicial decision," *id.*). This last question does not merit full briefing and oral argument because this Court has recently, and definitively, rejected overruling *Roe v. Wade*, 410 U.S. 113 (1973).[15]

But two important questions are actually raised by this conflict; both should be decided by summarily affirming the court below. The first is whether the right to privacy guaranteed by this Court's decisions in *Roe*, *Doe v. Bolton*, 410 U.S. 179 (1973), *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), *Thornburgh v. ACOG*, 476 U.S. 747 (1986), and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), is to have any continuing vitality. Indeed, the State ultimately argues that *Roe* and its progeny should all be overruled by this Court in order to save the Act. Pet. at 16-18. The court below properly respected the vitality of these precedents, declining to rewrite the Act in a manner that, ultimately, would violate each of them. It holds, quite straightforwardly, that a statute whose plain language prohibits a sequence of actions undertaken by physicians in most second-trimester surgical abortion procedures is unconstitutional. *See Danforth*, 428 U.S. at 76-79. In contrast, the Seventh Circuit's opinion in *Hope Clinic* flouts each of these precedents by diminishing the scrutiny given to state laws

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any "living unborn child" if a "substantial portion" of it has been delivered from the woman's *uterus*. The Act does not define "substantial portion" as "up to the head," nor is it limited to delivery out of the woman's body.

[15] The question of whether to overrule *Roe*, was asked and answered in the negative by this Court in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), after careful review of the value of *stare decisis* and the jurisprudential underpinnings of *Roe*. *Casey*, 505 U.S. at 854-69. Neither the State nor the Seventh Circuit in *Hope Clinic* presents any compelling argument that justifies revisiting the constitutional protection accorded a woman's right to terminate a pregnancy before viability.

infringing the right to abortion to, or below, rational basis review.

The second, subsidiary question is whether a broad state statute directly prohibiting constitutionally protected conduct -- like either Nebraska's or Wisconsin's -- may be rewritten by a federal court in a manner demonstrably contrary to the plain meaning of the language chosen by the legislature, and even when that rewriting of the statute still leaves it susceptible, on a number of grounds, to constitutional attack.[16]

Thus, if the Court grants the petition, it should grant it to decide the two questions described above and to summarily affirm the court below. This would resolve the conflict in the Circuits, which should be resolved, in a manner consistent with judicial economy. Then, upon a timely petition for review, this Court should summarily reverse the Seventh Circuit's decision in the *Hope Clinic* cases.[17] Doing so will resolve numerous pending cases regarding "partial-birth

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[16] The court below reached only one of the several grounds upon which the district court held the Act unconstitutional. The other grounds were: that the Act's prohibition on D&X-type abortions imposes an undue burden on the abortion right by requiring women "to endure appreciably greater risks to their health and lives than are necessary," S-73, *see also* S-70 n.37 (Act's "medical exception would not apply to Carhart's patients [obtaining D&X abortions] because risks to maternal health are not considered and relative surgical risks are not considered either"); and that the Act is void for vagueness because the phrase "substantial portion" is "meaningless to doctors, lay people and prosecutors alike," S-87. Each of these alternative grounds is firmly rooted in the decisions of this Court.

[17] In the *Hope Clinic* cases, the plaintiffs have indicated, by seeking a stay of the Seventh Circuit's mandate from Justice Stevens as Circuit Justice for the Seventh Circuit, their intention to petition for a writ of certiorari. Justice Stevens granted the stay, Nos. 99A427 and 99A428 (Stevens, Circuit Justice Nov. 30, 1999), thus effectively deferring enforcement of the Illinois and Wisconsin statutes at issue in those cases until this Court decides whether to grant review.

abortion" bans in litigation in numerous courts, *see* n.13 *supra*, and assist in forestalling future equally irrational efforts to interfere with the right to privacy. But if the Court restricts its consideration to the questions presented in the petition, the petition should be denied.

I. THE DECISION OF THE COURT BELOW IS IN COMPLETE HARMONY WITH THIS COURT'S ABORTION DECISIONS AND SO SHOULD BE SUMMARILY AFFIRMED.

The State does not seriously contend that the decision of the court below conflicts with the abortion jurisprudence of this Court. Indeed, perhaps recognizing this, the State instead asks this Court to overrule *Roe v. Wade*, 410 U.S. 113 (1973), and to subject women's privacy rights to the caprice of legislative majorities. Unfortunately, the Seventh Circuit's opinion in *Hope Clinic* dispenses with principles established in *Roe*, 410 U.S. at 165 (statute regulating abortion must contain exception for woman's health; statute regulating abortion must be "tailored to the recognized state interests," as well as important principles established in subsequent cases. *See Bolton*, 410 U.S. at 188 (physicians need not await a criminal prosecution to test validity of state abortion statute); *Danforth*, 428 U.S. at 77-79 (state may not ban abortion method even if it is not the safest method); *Colautti v. Franklin*, 439 U.S. 379, 390-97 (1979) (statute that, through imprecision, chills exercise of right to abortion is invalid); *Thornburgh*, 476 U.S. at 768-69 (state cannot interfere with physician's ability to keep woman's health paramount in choice of abortion method); *Casey*, 505 U.S. at 878-79 (if either purpose or effect of abortion statute is to impose undue burden, it is invalid; statute must further interest in potential life or maternal health; woman's health takes precedence over state's interest in potential life). As a consequence, a conflict has been created that should be

resolved summarily and definitively by this Court in favor of *Roe* and its progeny.

The State also asks this Court to overturn *Roe* in an alternative way: by recognizing that once any part of the living fetus, at any point in pregnancy, is in the vagina,[18] it is entitled to protection as a "partially born child" under the Fourteenth Amendment.[19] Such recognition would prohibit most abortions, because most abortions involve removing a living fetus part way out of the uterus before killing it. Thus, this proposed constitutional protection for the "partially born" is nothing more than a backdoor effort to overturn *Roe*, and should be rejected along with the State's frontal assault on *Roe*.

That the decision below is in complete agreement with this Court's precedents is hardly in dispute; it is the validity of the precedents themselves that the conflict with the Seventh Circuit raises. In *Danforth*, this Court reviewed a ban on abortions performed with "insertion of 'a saline or other fluid,'" 428 U.S. at 78 (quoting Missouri statute), finding that this broad language could also "include within its proscription the intra-amniotic injection of prostaglandin itself and other methods that may be developed in the future." *Id.* The Court did not narrow the statute at issue in *Danforth* to saline amniocentesis abortions only, both because the statute was (obviously) not susceptible to such a construction and because the statute, like the Nebraska

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[18] Apparently, out of either unfamiliarity with or disregard for women's anatomy, the State equates "outside the womb" with "outside the woman's body." However, the vagina is part of the woman's body, and the Act applies to any living fetus delivered into the vagina.

[19] The Act's text itself does not employ this proposed category of "partially born children." Instead, it uses the term "unborn child" to refer even to a living fetus that has been partly delivered into the vagina. *See generally* Pet. 2 (quoting the Neb. Rev. Stat. § 28-326(9) (Supp. 1998)). Thus, the State's proposed category comes across, at best, an effort at a *post hoc* rationalization for the Act.

partial-birth abortion ban, suffered from a number of other flaws.

Each of the Act's other constitutional deficiencies -- which make a rewriting of the Act doubly improper, *see* Point II *infra* -- are also established in this Court's precedents. First, the Act's lack of any health exception allowing the physician to use the prohibited methods (whatever they may be) renders it unconstitutional under *Casey*. 505 U.S. at 880.

Second, the Act's prohibition of abortions accomplished through vaginal removal of the fetus while failing to "prohibit techniques that are many times more likely to result in maternal death," *Danforth*, 428 U.S. at 78, demonstrates that it does not serve the state's interest in maternal health. *See generally Hodgson v. Minnesota*, 497 U.S. 417, 454-55 (1990) (Minnesota's failure to require involvement of two parents in any other area of decisionmaking by minors cast doubt on the reasonableness of such a requirement for abortion); *Planned Parenthood v. Doyle*, 162 F.3d 463, 470 (7th Cir. 1998) (Wisconsin statute banning partial birth-abortion does not serve state interest in maternal health). This is true even if the Act bans only some subset of D&E procedures, because at the same time the Act would clearly allow hysterotomy and hysterectomy procedures that are less safe than D&E procedures.[20]

Third, the Act does not serve the state's interest in potential life, or, assuming *arguendo* that it does, it does not do so by permissible means. Whether it bans most D&E

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[20] Moreover, even if labor induction methods of abortion were legal under the Act, it would fail to promote the state interest in maternal health. The district court found that, during the period from 16 to 20 weeks, when Dr. Carhart's abortion methods are prohibited by the Act, induction is not as safe for the woman, involves "greater pain and economic cost," and is "not generally available to most women in Nebraska." S-70 n.38.

abortions, or just those that meet some definition of D&X abortions, the Act would force women to undergo abortions that involve inducing fetal demise *in utero*, or else to forgo an abortion altogether. Not only did the district court find that causing fetal demise in utero "before the 20th week of pregnancy carries with it appreciable maternal health risks, no maternal benefits, and is not always possible," S-63; *see also Carey v. Population Servs. Int'l*, 431 U.S. 678, 715 (1977) (Stevens, J., concurring in part and concurring in judgment) (statute which might have promoted state interest at cost of inflicting harm was still invalid), but inducing fetal demise obviously does not promote the state's interest in potential life. Of course, forcing women to forgo abortions altogether is simply impermissible.

Fourth, the purpose of the Act is solely to create obstacles to abortion, for, as explained above, it serves no legitimate state interest. Thus, the Act, like the saline amniocentesis method ban invalidated in *Danforth*, "comes into focus . . . as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks." 428 U.S. at 79. Having no legitimate purpose, the Act fails the purpose prong of *Casey*'s undue burden test, for its purpose is simply to "hinder" women's free choice. *See Casey*, 505 U.S. at 877.

Moreover, although *Casey* authorizes the States to promote their interest in potential life by persuading the pregnant woman to carry her pregnancy to term (so long as the persuasive means chosen do not have the purpose or effect of imposing substantial obstacles),[21] it does not

[21] And, indeed, despite the State's hyperbolic protestation that "[i]f a State cannot ban the partial-birth abortion/D&X procedure, there is effectively no limit on abortion at all," Nebraska has enacted numerous statutes limiting abortion. First, consistent with *Roe*, Nebraska prohibits abortions after viability except where necessary to protect the woman's life or health, Neb. Rev. Stat. § 28-329, and requires any post-viability abortion to be performed by a method that favors fetal survival so long as that method is compatible with preserving the woman's life and health, Neb. Rev. Stat. § 28-330. Nebraska also enforces numerous statutes designed to promote its interest in potential life through means endorsed by this Court. Thus, it requires parental notice for unemancipated minors seeking abortions, Neb. Rev. Stat. §§ 71-6901-08, thereby giving parents an opportunity to persuade their daughters to carry to term; it prohibits most public funding for abortion, *see Orr v. Nelson*, 902 F. Supp 1019 (D. Neb. 1994), *aff'd*, 60 F.3d 497 (8th Cir. 1995), *cert. denied*, 516 U.S. 1074 (1996), thereby "encouraging childbirth," *Harris v. McRae*, 448 U.S. 297, 325 (1980); and it requires women seeking abortions to receive certain state information designed to encourage childbirth at least 24 hours before the procedure, Neb. Rev. Stat. § 28-327. Each of these statutes is a limitation on abortion that appears to be consistent with the abortion jurisprudence of this Court. On the other hand, if Nebraska is permitted to ban "partial birth abortion/D&X," as it asserts it must be able to do, even where such a ban fails to promote any valid state interest, there would appear to be no limit on the State's power to ban both existing and newly developed safe and effective abortion techniques.

authorize the States to "promote" that interest by interfering with the method of abortion once the woman has decided to end her pregnancy despite all efforts to persuade her otherwise. Rather, this Court's precedents establish that government may not interfere with the woman's choice of abortion method, *see, e.g.*, *Thornburgh*, 476 U.S. at 768-69; *see also Jane L. v. Bangerter*, 61 F.3d 1493, 1502-05 (10th Cir. 1995), *rev'd on other grounds sub nom. Leavitt v. Jane L.*, 518 U.S. 137 (1996), even after viability. This is because the decision about how the abortion should be carried out is one implicating the woman's right to bodily integrity, a strand of the woman's privacy right reaffirmed in *Thornburgh* that remains undiminished by *Casey*.

For these reasons, the Court should summarily affirm the decision of the Court below in an opinion that instructs the lower federal courts to respect the continuing vitality of *Roe* and *Casey* and intervening precedents.

II. THE CONFLICT BETWEEN THE DECISION OF THE EIGHTH CIRCUIT BELOW AND THAT OF THE SEVENTH CIRCUIT SHOULD BE RESOLVED IN FAVOR OF THE JUDICIALLY-RESTRAINED APPROACH TO STATE STATUTORY CONSTRUCTION ADOPTED BY THE EIGHTH CIRCUIT.

It is a bedrock principle of this Court's jurisprudence and of our system of federalism that a federal court will not "rewrite a state law to conform it to constitutional requirements." *Virginia v. American Booksellers Ass'n, Inc.*, 484 U.S. 383, 397 (1988). *See also Reno v. ACLU*, 521 U.S. 844, 884 (1997) (rejecting proposed narrow construction of nonseverable terms in federal statute because "the text or other source of congressional intent" failed to "identif[y] a clear line that this Court could draw"). Because the court below properly adhered to these principles, the conflict between its approach and the activist approach of the Seventh Circuit in *Hope Clinic* should be resolved in favor of the court below.

The court below properly refused to rewrite the Act for two reasons.[22] First, while a "narrowing construction" of a state statute in order to save it is permissible when the interpretation is one to which the state statute is "readily susceptible," *American Booksellers*, 484 U.S. at 397, the Act is not reasonably susceptible to a construction more limited than that which its plain language dictates. Instead, the State's proposed interpretation of the Act confining it to "only the D&X procedure," App. 16, would have required the court of appeals to "twist the words of the law and give them a meaning they cannot reasonably bear." *Id.*

---

[22] In contrast, the conflicting *Hope Clinic* opinion eagerly rewrites two state's statutes, using the vehicle of unprecedented "precautionary injunctions" in an effort to limit their reach.

Second, a limiting interpretation of the Act, such as sought by the *Hope Clinic* court, would not "conform [the Act] to constitutional requirements." Instead, such a revision would simply create a new, but also unconstitutional statute, for reasons not reached by the court below but addressed by the district court:

(1) it would result in a prohibition on the safest previability abortion method available in Nebraska after 16 weeks. Such a prohibition is invalid under this Court's decisions in *Danforth* and in *Thornburgh v. ACOG*, 476 U.S. 747, 768-69 (1986), and conflicts with the basic premise of *Roe v. Wade*, 410 U.S. 113, 163-64 (1973), reaffirmed in *Planned Parenthood v. Casey*, 505 U.S. 833, 880 (1992), recognizing that maternal health trumps the state interest in fetal life throughout pregnancy;

(2) it would create a statute that serves no legitimate state interest whatsoever. By forcing a woman to use a less safe abortion technique, the Act would neither serve the state's interest in maternal health nor in potential life, thus violating the basic requirement of *Roe* and *Casey* that an abortion restriction must serve one of these interests by permissible means.[23] *See Doyle*, 162 F.3d at 470 (reversing denial of preliminary injunction against Wisconsin partial-birth abortion statute); and

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[23] The State adverts to "the States' interests in preserving human life," Pet. 13, but does not explain how fetal life can be preserved by the Act except by preventing women from having abortions at all, a result that is flatly unconstitutional. Moreover, the only other state interest asserted appears to be an interest in stopping "ghastly, cruel and painful" medical procedures. Pet. 17. Putting aside the fact that the record contains no evidence that any procedures banned by the Act are "ghastly, cruel [or] painful," it bears observation that, were this interest in preventing cruelty to the fetus legitimate, the State would employ it to justify banning all D&E abortions. *See id.* This result would require this Court to overturn *Roe*, *Casey*, *Thornburgh* and *Danforth*.

(3) it would replace the Act's use of the impermissibly vague term "substantial portion" with the vagueness inherent in trying to define a "D&X abortion," or a set of prohibited D&X variations, and in trying to describe what distinguishes such abortions from all other variations of the D&E abortion method. This vagueness is readily apparent in the effort by the Seventh Circuit in *Hope Clinic* to describe tentative "precautionary injunctions" that would temporarily limit the applicability of Illinois's and Wisconsin's partial-birth abortion bans to "D&X" abortions or to D&E abortions that are not "normal." There, the court of appeals directed that:

> [T]he state laws may not be applied to a normal D&E or induction until after the state has provided additional specificity, by statutory amendment, regulations, or judicial interpretation (which could arise either from civil litigation . . . or from criminal prosecutions in which the parties disagree about whether the medical procedure properly may be labeled a D&X).

App. 43.

Thus, in contrast to the approach of the court below, the Seventh Circuit's approach runs afoul of this Court's understanding of separation of powers in two ways: it rewrites state statutes, thus usurping the authority of state legislatures; and it directs the issuance of federal "precautionary injunctions," thus usurping, in addition, the authority of state courts. The effect of this violation is profoundly harmful: "It would certainly be dangerous if the Legislature could set a net large enough to catch all possible offenders and leave it to the courts to step inside and say who could be rightfully be detained and who should be set at large. This would, to some extent, substitute the judicial for the legislative department of the government." *United States v. Reese*, 92 U.S. 214, 221 (1875) (*quoted in Reno*, 521 U.S.

at 885 n.49). *See also Whitehouse*, 66 F. Supp. 2d at 316 (observing that Fourth Circuit judge's "detailed editing of" language of Virginia partial-birth abortion ban in opinion staying preliminary injunction "confirms that a court could only save the [partial-birth abortion statute] by stepping in as a super-legislature"). As this Court reiterated in *Reno*, rewriting of statutes by judicial fiat removes the legislature's "incentive to draft a narrowly tailored law in the first place." *Osborne v. Ohio*, 495 U.S. 103, 121 (1990) (*quoted in Reno*, 521 U.S. at 885 n.50). In contrast to the Seventh Circuit's approach, the approach of the court below is consistent with these precedents. It takes the Nebraska Legislature at its word, and refuses, temporarily or permanently, to redraft the Act.

CONCLUSION

For all the foregoing reasons, the petition for a writ of certiorari should be denied, but, if granted, the decision below should be summarily affirmed.

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Dated: December 14, 1999.

APPENDIX

Exhibit 31

Congress of the United States
House of Representatives
Washington, DC 20515

March 18, 1996

H.R. 1833 is Constitutional

Dear Colleague:

In a March 11 letter five of our colleagues cited an Ohio abortion case as proof that H.R. 1833, the Partial-Birth Abortion Ban Act, is unconstitutional. Even if the dubious reasoning of the Ohio court withstands an appeal, the decision has no bearing on H.R. 1833.

The Ohio bill attempted to ban "Dilation and Extraction (D&X)" or "Brain Suction" abortions. A district court judge found that the definition of the abortion technique was vague because there are several abortion techniques that use suction, and therefore, an abortionist might not have sufficient notice as to which technique was actually banned.

H.R. 1833 does not ban "D&X" or "Brain Suction" abortions. H.R. 1833 bans any "abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery." The ban would have the effect of prohibiting any abortion in which a child was partially delivered and then killed -- no matter what the abortionist decides to call his particular technique.

Roe v. Wade declared that "unborn" children were not persons under out Constitution, but the decision left intact a

Texas statute that outlawed killing a partially born child. We are not considering the fate of unborn children in H.R. 1833. We are considering how our country will treat babies who are in the process of emerging from the womb.

But even if we considered these partially-born children to be non-persons, H.R. 1833 is constitutional under *Planned Parenthood v. Casey* because the ban does not place an "undue burden" on a woman's "right to choose" whether to have an abortion. There are a number of more widely used abortion techniques in both the second- and third-trimester of pregnancy. Even President Clinton, who has threatened to veto H.R. 1833, did not argue in his letter to the House and Senate Judiciary Committee Chairmen that the ban places an "undue burden" on women.

Regarding the issue whether a "health" exception is required, the Ohio case discusses this type of exception in the context of a ban on all third-trimester abortions. The discussion would not apply to a ban on a particular type of abortion. Even if the discussion did apply, H.R. 1833 allows any abortion in which the abortionist does not partially deliver the child alive before killing the child to be performed for "health" reasons. Inserting a "health" exception in H.R. 1833 would allow an abortionist to kill a child in the process of delivery for -- as the judge in the Ohio decision asserts -- both psychological and emotional reasons.

Opponents of H.R. 1833 cloak themselves in the mantle of *Roe v. Wade*, but even the *Roe* Court explicitly rejected the argument that the right to an abortion is absolute. The Court clearly stated that there is no right that entitles a woman "to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses."

Our five colleages on the Judiciary Committee are still missing the point of the Partial-Birth Abortion Ban Act.

Let us be clear: in H.R. 1833, we are protecting children from having their lives taken while being delivered from their mother's womb. As a civilized society we can do no less.

Sincerely yours,

/s/	/s/
Charles T. Canady	Henry J. Hyde
/s/	/s/
Bob Inglis	Michael P. Flanagan
/s/	/s/
F. James Sensenbrenner, Jr.	Martin R. Hoke

Excerpts from Oral Argument before the United States Court of Appeals for the Eighth Circuit,
***Carhart v. Stenberg*, Nos. 98-3245 & 98-3300**
(Apr. 19, 1999)

THE COURT: Mr Grasz, if you lost a leg wouldn't you have lost a substantial portion of your body?

MR. GRASZ: Yes, your honor.

THE COURT: Well?

MR. GRASZ: However, that's, that's exactly my point, it has to be taken in the context of the statute read as a whole and I would like to go through point by point to explain how that is distinguished. What the plaintiff wants this Court to overlook is the fact that the meaning of the term substantial portion is never even an issue until a number of other thresholds are first crossed. The term substantial portion comes into play in the context of defining the phrase, partially delivers, vaginally, a living unborn child. Partial vaginal delivery of a living unborn child can not logically refer to passage of dismembered body parts through the vaginal cavity. One must strain to reach such a conclusion. And one technique that is used, is employed is to use an extremely technical definition of the word deliver rather than its common meaning. More importantly, Nebraska statute specifically requires that the partial delivery be deliberate and intentional *and* that it be done for the purpose of performing a procedure that is intended to kill the unborn child. The D&E abortion procedure simply does not fit the statutory definition of partial-birth abortion. Contradicting its own holding, the district court below graphically described how the dismemberment in a D&E abortion occurs due to traction against the cervical os. And I'm sure that counsel for the Appellant will disagree with this, but I think if you look at the record it's clear and I would quote the Appellees own

brief on page 12, quote, the dismemberment is a result of the traction of the fetus against the cervical os. In other words, the dismemberment happens before the severed part enters the vaginal cavity. Otherwise, it would be an unnecessary and purposeless mutilation. And I would cite the Sixth Circuit majority in *Voinovich* where they stated, quote the D&E procedure involves dismembering the fetus in utero before compressing the skull by means of suction. That's 130 F.3d at page 199 for the Sixth Circuit was distinguishing the D&E from the D&X procedure. The court then added a footnote at that point referring favorably to the federal language which is the same as Nebraska's statute, that's footnote number nine. In addition, the passage of severed parts through the vaginal cavity does not meet the death causing purpose requirement of the statute.

THE COURT: Could there not be an unsevered part in the D&E?

MR. GRASZ: Yes, but it's still attached, there's been no dismemberment in the vagina it takes place in the uterus and then the dismembered part is then passed through the vaginal cavity.

(5)

No. 99-830

Supreme Court, U.S.
FILED
DEC 22 1999
CLERK

In The

Supreme Court of the United States

DON STENBERG, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

REPLY TO BRIEF IN OPPOSITION

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REPLY TO RESPONDENT'S BRIEF IN OPPOSITION

I. The Respondent Acknowledges There Is A Conflict Between The Decisions of the Seventh and Eighth Circuits Which Should Be Resolved By This Court

The Respondent candidly acknowledges that "The State correctly points out that the . . . decision of the court below is in conflict with a . . . decision of the Seventh Circuit, namely *Hope Clinic v. Ryan* . . . . " (Respondent's Brief In Opposition at 7). *See also id.* at 16 ("The conflict between the decision of the Eighth Circuit below and that of the Seventh Circuit should be resolved. . . . "). Thus, it is clear that "a United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter." Supreme Court Rule 10(a). The Court should grant certiorari in this case to resolve this conflict.

II. The Court Should Grant Certiorari to Uphold The Fundamental Rule of Statutory Construction Favoring Constitutional Interpretations of State Legislative Enactments

In what may well constitute the ultimate legal irony, the Respondent argues strenuously that this Court should refuse to adopt a saving construction of Nebraska's partial birth abortion statute, as was done by the Seventh Circuit, but rather should strictly adhere to what the Respondent asserts is the statutes' "plain language". (Respondent's Brief in Opposition at 16-19). Thus, while advocating a strict construction of statutes furthering the States' legitimate interests in partially-born children, the

Respondent simultaneously relies on penumbral emanations as the source of his constitutional right to literally tear the arms and legs off of living, unanesthetized, mid and late-term, human children (Supp.App. 11-13), and/or pull them from the womb, puncture their skulls and suction out their brains (Supp.App. 17). *See* Respondent's Brief in Opposition at 16 (advocating a "judicially-restrained approach to statutory construction" and opposing adoption of a saving construction). *See also id.* at 18 (asserting that adoption of a saving construction of the statute would result in "usurping the authority of state legislatures" and would "substitute the judicial for the legislative department.").

Notwithstanding the new-found fervor of the Respondent for strict judicial construction, fundamental considerations of federalism and rules of statutory construction favor a saving construction of the statute. As this Court has stated, "every reasonable construction must be resorted to, in order to *save* a *statute* from unconstitutionality." *Rust v. Sullivan*, 500 U.S. 173, 190, 111 S.Ct. 1759, 1771 (1991) (quoting *Edward J. DeBartolo Corp. v. Florida Gulf Coast Building & Construction Trades Council*, 485 U.S. 568 (1988)). *See also Webster v. Reproductive Health Services*, 492 U.S. 490, 109 S.Ct. 3040 (1989) (reversing Eighth Circuit decision declaring a Missouri abortion statute unconstitutional and adopting a saving construction of the statute). The Court should grant certiorari in this case to uphold the fundamental rule of statutory construction favoring constitutional interpretation of State legislative enactments.

III. The Respondent's Arguments on the Merits Require Full Briefing, and the Court Should Grant Certiorari on Each Issue Presented

The Respondent devotes a significant portion of his Brief in Opposition to discussing the merits of the case in an attempt to persuade the Court to "summarily affirm" the lower court. The Respondent's arguments, however, contain a number of mischaracterizations of the evidence, testimony, arguments below, and even portions of the relevant law. The important issues raised in this case require full and thorough briefing for proper disposition by the Court. The Court should grant certiorari on each issue presented and require full briefing.

CONCLUSION

It shocks the conscience that in the United States of America a human child can be literally pulled from the womb and then cruelly killed by having his or her skull punctured and brains suctioned out. The State of Nebraska has a legitimate interest in banning this barbarous procedure, and the Petitioners respectfully request

the Court to grant a writ of certiorari on each of the questions presented in the Petition for Writ of Certiorari.

Respectfully submitted,

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Supreme Court, U.S.
FILED
DEC 14 1999
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(4)

No. 99-830

In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al., *Petitioners*,

v.

LEROY CARHART, M.D., *Respondent*.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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QUESTIONS PRESENTED

Amici Curiae request the Court to grant a writ of certiorari for the first two of Petitioners' questions, as summarized below. Amici Curiae do not believe that Petitioners' final two questions need be reached to resolve this case.

I. Whether the Eighth Circuit erred in broadly construing Nebraska's partial-birth abortion ban (unlike the Seventh Circuit's narrow construction of similar partial-birth abortion bans), thereby concluding that it reached conventional abortion methods, not just the intact D&X procedure?

II. Whether the Eighth Circuit erred by holding that Nebraska's law imposed an undue burden on the right to abortion?

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INTEREST OF AMICI CURIAE

Amici Curiae are states and state actors that have an interest in having this Court accept a partial-birth abortion case for review. Most of Amici Curiae states have enacted statutes banning partial-birth abortion procedures. Over half of the states have enacted bans on partial-birth abortion. Some of these statutes are in effect, but others are under federal court injunction. The states have a strong interest in having bans against partial-birth abortion declared constitutionally permissible so that their own similarly-worded bans may be enforced.

SUMMARY OF THE ARGUMENT

Amici Curiae ask the Court to accept one or more partial-birth abortion cases for review, only requesting in the present case review of the first two questions presented by Petitioners Stenberg et al. concerning construction and undue burden. The partial-birth abortion issue is ripe for review because it is one of great national importance – as evidenced by the passing of partial-birth abortion bans in nearly three-fifths of the States, extensive litigation, and extensive congressional activity – and because of developed evidentiary records (the Nebraska and Wisconsin cases had full trials), polished arguments, and a conflict between the Seventh and Eighth Circuits.

ARGUMENT

I. Amici Curiae Request Review of the First Two Questions Presented.

Petitioners Stenberg et al. presented four questions in their petition for a writ of certiorari. Amici Curiae believe this case can be resolved on the basis of the first two questions presented: (1) whether the Nebraska act should be narrowly construed so as to reach only a procedure known as intact D&X, and (2) whether, as so construed, the act imposes an undue burden on the right to abortion? Therefore, Petitioners' latter two questions need not be reached: (3) whether a human being delivered but for its head is a Fourteenth-Amendment person, and (4) whether the Court should now recognize abortion as a legislative issue?

The United States Court of Appeals for the Seventh Circuit recently upheld similar partial-birth abortion prohibitions in consolidated cases from Illinois and Wisconsin without having to reach issues (3) and (4) presented by Petitioners Stenberg et al. (These cases will soon be the subject of petitions for a writ of certiorari in this court, Justice Stevens having granted stays. *Planned Parenthood of Wis. v. Doyle*, 99A428 (U.S. Nov. 30, 1999) and *Hope Clinic v. Ryan*, 99A427 (U.S. Nov. 30, 1999) (orders staying mandate of Seventh Circuit)).

Similarly, the United States Court of Appeals for the Fourth Circuit stayed a Virginia district court's preliminary and permanent injunctions against enforcement of a similar partial-birth abortion statute without having to reach issues (3) and (4). *Richmond Med. Ctr. for Women v. Gilmore*, 144 F.3d 326 (4th Cir. 1998) (Luttig, J.), *aff'd*, 183 F.3d 303 (4th Cir. 1998) (staying prelim. injunction); *Richmond Med. Ctr. for Women v. Gilmore*, No. 98-1930(L) (4th Cir. Sept. 14, 1999) (order staying permanent injunction).

In fact, the federal partial-birth abortion ban bills, upon which Nebraska's ban and most other state bans are modeled, were premised in part on the belief that abortion jurisprudence does not

even govern a statute involving partial-birth or parturition (but if it does govern then there is no "undue burden" on the abortion right). *See* H.R. Rep. No. 104-267, at 9 (1995)[1] (the report of the House Committee on the Judiciary recommending passage of Partial-Birth Abortion Ban Act of 1995); *The Partial Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the Sen. Comm. on the Judiciary*, 104th Cong., 1st Sess. 172 (Nov. 17, 1995) (written Testimony of Prof. Douglas W. Kmiec) (setting out basically the argument given herein). This understanding of the Constitution and this Court's decisions is discussed more fully below. As shall also be shown, partial-birth abortion bans may be readily upheld even within this Court's current abortion jurisprudence.

A. Serious federalism concerns are raised by the partial-birth abortion cases, including construction and the facial challenge standard.

The partial-birth abortion cases raise important federalism issues requiring resolution by this Court, including statutory construction and the facial challenge standard.

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[1]The twelve-page report discussed the constitutionality of the partial-birth abortion ban under various levels of scrutiny. It declared that:

> The Supreme Court has never decided the constitutional status of a child in the process of being born. But even under *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, H.R. 1833, the "Partial-Birth Abortion Ban Act of 1995," is constitutional both before and after fetal viability. . . . In fact, in *Roe* the Court specifically noted that a Texas statute that made killing a child during the birth process a felony had not been challenged. . . . [H.R. Rep. No. 104-267, at 9.]

Under an appropriately narrow construction,[2] partial-birth abortion bans reach only one rarely-used procedure, intact D&X. Such limited bans pose no undue burden (even if abortion jurisprudence is applicable) because they have neither the purpose nor the effect of placing a substantial obstacle in the path of women seeking an abortion. Furthermore, the limited bans are amply justified by sufficient and indeed compelling state interests, including interests in protecting partially-born human life, erecting an impenetrable barrier against infanticide, and protecting maternal health, as well as a moral interest in preventing an especially offensive procedure.

However, the Eighth Circuit and numerous other federal courts have refused to adopt a narrow construction of partial-birth abortion statutes – refusing to show any deference to reasonable constructions offered by state enforcement authorities – and have instead adopted the untenable position that state legislatures had the purpose of banning virtually all common methods of abortion in open defiance of this Court's holdings on abortion.[3] This Court has made it clear that it will not "cast a blind eye on over-reaching by

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[2]A threshold issue, not addressed by the Eighth Circuit, is whether federalism mandates that the state courts be afforded the first opportunity to give the new state statute an authoritative construction that may eliminate or narrow the federal constitutional issues presented here, under the doctrine of *Railroad Comm'n v. Pullman Co.*, 312 U.S. 496 (1941). While the Seventh Circuit was more sensitive to the demands of federalism, it too failed to address the advisability of *Pullman* abstention.

[3]In accord with its concern for federalism, this Court has repeatedly indicated that the federal courts should accept a state's representations – whether sworn or unsworn, at oral argument or in memoranda, at the trial level or on appeal – as to the scope or meaning of a statute or ordinance. *E.g.*, *Forsyth County v. Nationalist Movement*, 505 U.S. 123, 131 (1992); *Ward v. Rock Against Racism*, 491 U.S. 781, 795-96 (1989); *Frisby v. Schultz*, 487 U.S. 474, 483 (1988); *Edwards v. Aguillard*, 482 U.S. 578, 595 (1987); *Hoffman Est. v. Flipside, Hoffman Est.*, 455 U.S. 489, 494 n.5 (1982); *DeFunis v. Odegaard*, 416 U.S. 312, 317 (1974). Federalism also mandates the presumption that the state legislature acted with knowledge of existing constitutional restrictions and did not intend to transgress those restrictions. *See, e.g.*, *McDonald v. Board of Election Comm'rs*, 394 U.S. 802, 809 (1969).

lower federal courts" and "undoubtedly should" grant certiorari in order to prevent "blatant federal-court nullifications of state law" by means of "state-law determinations that seem plainly wrong." *Leavitt v. Jane L.*, 518 U.S. 137, 144-45 (1996).

The Fourth and Seventh Circuits have set the example of how a partial-birth statute ought to be construed, adopting narrow constructions under which only a procedure known as intact dilation and extraction[4] is prohibited. *Richmond Med. Ctr. for Women v. Gilmore*, 144 F.3d 326 (4th Cir. 1998) (Luttig, J.), *aff'd*, 183 F.3d 303 (4th Cir. 1998) (staying prelim. injunction); *Richmond Med. Ctr. for Women v. Gilmore*, No. 98-1930(L) (4th Cir. Sept. 14, 1999) (order staying permanent injunction).

However, most other federal courts have, as one commentator noted (concerning a case involving an early statute designed to stop partial-birth abortion),

> crafted an opinion unconstrained by the Supreme Court's 'cardinal principle' [that federal courts must give state statutes a narrowing construction where reasonably possible to save them from constitutional assault] or any other standard of statutory interpretation. Rather, the opinion's only consistent interpretive principle is that standards of interpretation are

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[4]Intact dilation and extraction ("intact D&X") typically involves two days of cervical dilation to allow the trunk of a fetus to be extracted, followed by feet-first extraction of a living, post-20-week human being from the uterus until the head lodges in the cervical os, at which time the child's skull is punctured and the brain is suctioned out to collapse the head and permit extraction of the child.. *See Hope Clinic v. Ryan*, — F.3d —, 1999 WL 974098 at *2 (7th Cir. 1999) (upholding partial-birth abortion bans from Illinois and Wisconsin).

It is possible to conceive of variations of the intact D&X that the statutes would also ban (for example, where the partially-delivered child is killed by lethal injection rather than by brain suction). As a factual matter, such potential variations do not figure in this case or in currently recognized abortion practices and need not be distinguished from the intact D&X procedure described above. For purposes of this brief, these variations will be treated as subsumed under the term "intact D&X."

selectively and temporarily employed and rejected to flout the Supreme Court's mandate and find the statute unconstitutional.

Comment, 112 Harv. L. Rev. 731 (1999) (discussing *Women's Med. Prof. Corp. v. Voinovich*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 523 U.S. 1036 (1998)).

Another key federalism issue is what standard should be applied to facial challenges to state statutes under the federal constitution. *United States v. Salerno*, 481 U.S. 739, 745 (1987), should apply to partial-birth abortion cases and plaintiffs should prevail only if they have demonstrated that there is "no set of circumstances under which the Act would be valid." *Id.* Under the *Salerno* rule, their challenges must fail because they have clearly failed to demonstrate that the Act is unconstitutional under many circumstances, e.g., as applied to post-viability elective intact D&X abortions not done to preserve maternal life or health, or when there is clearly no demonstrable differential health benefit in performing such an abortion. Even if *Salerno* does not apply and partial-birth abortion laws are subject to the "undue burden" test of *Casey*, they do not impose a substantial obstacle to abortion for a large fraction of women for whom they are relevant. *Cf. Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 895 (1992).

This Court has not resolved under what circumstances the *Salerno* test should apply to challenges to abortion legislation. The circuit courts are badly divided on the issue,[5] as is this Court. *Ada v. Guam Society of Obstetricians & Gynecologists*, 506 U.S. 1011 (1992); *Fargo Women's Health Org. v. Schafer*, 507 U.S. 1013 (1993).

In the partial-birth abortion cases, the important issue of what standard to apply in facial challenges – especially those involving abortion – is at issue. A partial-birth abortion case would be an

[5] *Cf., e.g., Barnes v. Moore*, 970 F.2d 12 (5th Cir. 1992) (employing *Salerno* facial challenge test in abortion case) *with Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452 (8th. Cir. 1995) (not employing *Salerno* test in abortion case). *See also City of Chicago v. Morales*, 119 S. Ct. 1849 (1999).

excellent vehicle for this Court to clarify the confused facial challenge issue. This is a vital federalism issue because federal courts are too readily striking down partial-birth abortion statutes with constitutional applications, depriving the states of the opportunity to construe and work out the meaning of their own statutes in the context of litigation involving real-life facts.

B. The partial-birth abortion cases raise the issue of precisely when the waxing state interest in a child outweighs the waning abortion interest.

The second issue that this Court should consider in a partial-birth abortion case is whether the abortion right is burdened at all. As noted above, the partial-birth abortion laws were premised in part on the notion that abortion jurisprudence does not even apply to a partial-birth abortion statute because the constitutional equation has changed with the changed location of human offspring. The abortion right involves an "unborn" human being (not one partially born) and the termination of a pregnancy (which barely exists, if at all, when a child is partially delivered). Therefore, there could be no "undue burden" under a *Casey* analysis because a *Casey* analysis would not apply.

But even if some abortion interest remains when a child is partially born, what is the precise moment when the waxing state interest in the child outweighs the waning abortion interest? Three-fifths of the States now say by their partial-birth abortion bans that the constitutional balance tips when the fetus moves out of the womb and becomes a partially-born child.

That, then, is the overriding substantive issue of this case – one which this Court has not decided, as shown next. It is the issue this Court ought to decide: Does an abortion right apply in a partial-birth situation and, if so, when must it yield to a state's interest in the child?

In *Roe v. Wade*, 410 U.S. 113 (1973), this Court held that the Texas anti-abortion statute at issue was unconstitutional, but the Court also noted that another Texas statute that bans killing children

in parturition was unchallenged and unaffected. As quoted by the Court, this statute provids as follows:

> Art. 1195. Destroying unborn child.—Whoever shall during parturition of the mother destroy the vitality or life in a child in a state of being born and before actual birth, which child would otherwise have been born alive, shall be confined in the penitentiary for life or for not less than five years.

Id. at 118 n.1.[6] The Texas parturition statute remains operative. Tex. Rev. Civ. Stat. Ann. art. § 4512.5 (West 1996). *See* Tex. Att'y Gen. Opinion H-369 (Aug. 13, 1974) (Texas parturition statute unaffected by *Roe)*; *Showery v. Texas*, 690 S.W.2d 689, 692 (Tex. Ct. App. 1985) (Texas parturition statute retains "current viability").[7]

The partial-birth abortion bans are based in part on the premise that states have a compelling interest in protecting the actual life of a child in the process of birth that is greater than, and distinguishable from, a state's interest in the "potential life" of a fetus in utero, which this Court has termed "substantial." *Casey*, 505 U.S. at 876. As the Wisconsin District Court found,

> when the physician kills a child in a partial birth abortion, the child "is merely inches from being delivered and obtaining full legal rights of personhood under the US Constitution." Accordingly, . . . partial birth abortion is "closer to infanticide than it is to abortion." The [Wisconsin State] legislators who filed an amicus brief [in the District Court] make similar arguments. The Court concludes that these facts demonstrate that the Act serves compelling state interests.

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[6]"Parturition" is "the action or process of giving birth . . . ." *American Heritage College Dictionary* 997 (1993).

[7]The plain language of the Texas law requires only that the child in parturition "would otherwise have been born *alive*," not that the child be "*viable*." The partial-birth abortion statutes likewise are not limited to viable children.

Planned Parenthood of Wis. v. Doyle, 44 F. Supp.2d 975, 982 (W.D. Wis. 1999) (citations omitted).

It logically follows from this Court's abortion decisions that the interest in protecting the life of the child in the process of birth arises from the change of legal status the fetus undergoes as she changes location, emerging from the maternal body toward complete birth. *Roe* affirmed the constitutional significance of the locational change that occurs as the child emerges from the maternal body. The child who has been completely born is a fully legal person, and the abortion liberty can make no claim on such a child's life. *Roe*, 410 U.S. at 156-57. Similarly, it follows that the child who is partially born is at least the subject of a compelling state interest, and any asserted abortion liberty holds, at most, diminished power over such a child.

"Birth" is "1.a. The emergence and separation of offspring from the body of the mother. b. The act or process of bearing young, parturition . . . ." *American Heritage College Dictionary* 141 (1993); "[t]he act of being born or wholly brought into separate existence." *Black's Law Dictionary* 154 (5th ed. 1979). "Born" is the "[a]ct of being delivered or expelled from mother's body, whether or not placenta has been separated or cord cut." *Id.* at 167.

A child who has fully emerged from the mother's body has obviously been "born" and is certainly a "person" who is the subject of compelling interests and the bearer of rights, as *Roe* recognized. But a child who is in the "process" of "being born," in the "act of being delivered," also falls within these common definitions. The state may properly conclude that such a child is no longer "unborn" – no longer fully under the sway of the abortion liberty as described by *Roe* and *Casey*.

This Court has acknowledged that a state's interest in the life of a fetus grows as the fetus becomes able to survive apart from the mother's body – as the fetus becomes "viable." *Roe*, 410 U.S. at 163-64; *Casey*, 505 U.S. at 875-76. Likewise, a state's interest in protection of the life of an unborn child increases and becomes compelling as she emerges from the maternal body and proceeds

toward full birth, reaching its apogee when live birth is completed. As the length of gestation has jurisprudential significance, so does location, and it is on the basis of the child's change in *location* that states assert a distinct compelling interest in protection of human life in the process of birth.

In the typical intact D&X abortion – the only procedure to which a properly construed partial-birth abortion statute applies – the child is delivered in a breech position, and only the child's head remains within the uterus. Much of the remainder of the child's body exists entirely outside the body of the woman. *See* Report of the AMA Board of Trustees ("One feature that distinguishes the D&X procedure from other destructive procedures is that the fetus may be partly outside the woman's body."). Surely, a state may conclude that such a child is no longer "unborn" and that the process of birth has proceeded to such a point that a state's interest in protection of the child has become compelling. "[T]he State cannot be faulted for acting where it can to outlaw an unnecessary procedure that in most cases in which it is used is literally inches away from being infanticide." *Doyle*, 44 F. Supp. 2d at 984.

Certainly, there is no precedent from this Court and there is no explicit language in the Constitution that precludes a state from determining that a child in the process of birth warrants special protection as the subject of a compelling state interest. This Court has simply not addressed the issue.

Nor has this Court held that gestational development/viability are the *exclusive* criteria by which the Constitution allows the State to measure its interest in the protection of human life.[8] "Although

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[8]Lower courts which have rather summarily dismissed the claim that thesState may maintain an enhanced interest in protection of the child in the process of birth have either erroneously regarded the gestational-development and viability criteria of *Roe* and *Casey* as exclusive or erroneously regarded the claim that locational criteria should be acknowledged as the addition of an unprecedented novelty to the analytic framework of *Roe* and *Casey*. *See Richmond Med. Ctr. for Women v. Gilmore*, 1999 WL 507453, at *35 (E.D. Va.) (July 16, 1999); (continued...)

abortion laws are typically justified according to the state's interest in maternal health or potential life, the *Casey* court specifically recognized that 'other valid state interest[s]' could justify a pre-viability abortion restriction.'" *Doyle*, 44 F. Supp. 2d at 983 (quoting *Casey*, 505 U.S. at 877).[9] In fact, it would be absurd to posit that the mere potential to live outside the womb – viability – has constitutional significance, while the actual fact of emergence of a living child from the womb has none whatever.

In short, a state may assert a distinct compelling interest in the protection of children in the process of birth in support of the Act. This locational interest exists apart from the substantial and compelling interests that the State might properly assert in

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Causeway Med. Suite v. Foster, 43 F. Supp. 2d 604, 615 (E.D. La. 1999); *Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1132 n. 48 (D. Neb. 1998) (incorporating *Carhart v. Stenberg*, 972 F. Supp. 507, 529 (D. Neb. 1997)); *Planned Parenthood of S. Ariz. v. Woods*, 982 F. Supp. 1369, 1377 (D.Ariz. 1997).

But these decisions are in error. First, as noted in text, this Court recognized that "other valid state interest[s]" might also justify pre-viability abortion restrictions. *Casey*, 505 U.S. at 877. Second, the locational criterion of birth is at the very core of the analytic framework of both *Roe* and *Casey*: The "right to abortion" applies only to "unborn" fetuses and has no claim on a child once birth is accomplished – when the child is not merely the subject of a compelling interest, but also a person and rights-bearer. Thus, although it is true that recognition of an enhanced state interest in the child in the process of birth elaborates and clarifies one element of *Roe*/*Casey* jurisprudence, it does not introduce an alien element into it.

[9]"After a trial, the district court in the Wisconsin case concluded that the intact D&X procedure is never necessary from the perspective of the patient's health." *Hope Clinic v. Ryan*, 1999 WL 974098 at *14 (citing *Doyle*, 44 F. Supp. 2d at 979-82). Neither the American College of Obstetricians and Gynecologists nor the American Medical Association could identify any situations in which the intact D&X would be the only medically appropriate option. *Id.* The Seventh Circuit declared that "[w]e proceed on the assumption, which appears to be shared by the American Medical Association, that the D&X is not the best or safest option in any articulable category of situations." *Id.*

"potential" human life based on gestational development, and it warrants special protection of the partially-born child.

The fully born child – whether "viable" or not – is the subject of a most compelling interest in the protection of the child's life, based solely on the locational change the child has undergone. Likewise, the child in the process of birth – whether "viable" or not – is the subject of an enhanced state interest by virtue of the child's change in location.

Furthermore, the abortion right wanes as a state's interest in protecting a partially born child waxes. This Court has recognized only a right to terminate pregnancy. *Casey*, 505 U.S. at 847. This right authorizes a pregnant woman to seek the means to terminate her pregnancy without state interference that unduly burdens her decision. *Id.* at 876-77. What are the outer boundaries of this right? Certainly, they do not extend beyond the maternal body. A woman seeking an abortion could not claim that this right authorizes killing a child who survives an abortion procedure and is born alive.

Partial-birth abortion bans also build upon this understanding of the abortion liberty. They acknowledge that pregnancy may be terminated under this Court's precedent, but deny that it may be terminated in a manner that purposefully seeks to kill the child once the child has begun the process of birth, a process marked by the passage of the living child's body from womb into birth canal to outside the woman's body. At this point, any claim of a right to terminate pregnancy is substantially obviated as pregnancy is terminated. The power and dominion of the abortion liberty diminish as its purpose is achieved and the child is delivered. Since the right to abortion does not include an independent right to assure fetal death, the abortion liberty cannot be asserted to justify a separate act to kill the child as the child proceeds out of the maternal body.

In sum, just as a state's interest in protection of the child increases as the child proceeds toward birth, the woman's right to abortion diminishes as the child leaves the maternal body. Partial-birth abortion bans do not prevent the termination of any pregnancy. They prevent killing a child after pregnancy has been terminated and the process of birth has been substantially completed.

Therefore, the abortion right is not even implicated in a parturition/partial-birth situation, so that this Court need not reach any issue related to the reconsideration of *Roe*. Even if a *Roe*/*Casey* analysis were appropriate, partial-birth abortion statutes should be upheld as marking the precise moment when the waxing state interest in protecting the partially-born child outweighs the waning interest in terminating a pregnancy. They should also be upheld as not constituting an undue burden because they leave in place safe alternatives to the only procedure that is banned under a proper construction of the statute, i.e., intact D&X, and because they promote other important state interests, such as maternal health.

This Court should accept review of a partial-birth abortion case to clarify this vital issue of the precise moment when any residual abortion right must yield to the interest a state protects when it outlaws infanticide. A majority of the States now say this happens during parturition, regardless of how the child arrives at its new location that transforms the constitutional equation.

II. A Partial-Birth Abortion Case Should Be Accepted for Review as a Matter of Great Public Interest.

The partial-birth abortion cases involve matters of great public interest, given that Congress has twice passed bills that were vetoed by President Clinton and only narrowly avoided being overridden. *See, e.g.*, Cong. Rec. S18228, roll call #596 (Dec. 7, 1995); Cong. Rec. H2929, roll call #94 (Mar. 28, 1996); Cong. Rec. H3338-3339, H. Doc. 104-198 (Apr. 10, 1996). Even now the issue remains alive in Congress, with the Senate recently passing a revised partial-birth abortion bill. (S.1692 passed 63-34, Oct. 21, 1999.) *See also* James Bopp, Jr. and Curtis R. Cook, *Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence*, 14 Issues in L. & Med. 3, 1998 (describing more fully the national history of the partial-birth abortion debate).

Following the lead of Congress, nearly three-fifths of the states have enacted some form of partial-birth abortion ban, most patterned closely after either the 1995 or 1997 federal models.[10]

The passage of these state partial-birth abortion bans has led to extensive litigation in federal courts.[11]

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[10]Twenty-seven states have enacted statutes substantially similar to Nebraska's: Ala. Code §§ 26-23-1, 26-23-3 to 26-23-4 (1998); Alaska Stat. §§ 18.16.050 (Michie 1998); Ariz. Rev Stat. Ann. 13.3603.01 (West 1997); Ark. Code Ann. §§ 5-61-201 to 5-61-203 (Michie 1997); Fla. Stat. Ann. §§ 390.11, 390.0111 (West 1998); Ga. Code Ann. § 16-12-144 (1998); Idaho Code § 18-613 (1998); 720 Ill. Comp. Stat. 513/5-5, 513/5-10, 513/5-20 (West 1998); Ind. Code Ann. §§ 16-18-2-267.5, 16-34-2-1(b), 16-34-2-7(d) (Michie 1998); Iowa Code § 707.8A (1998); Ky. Rev. Stat. §§ 311.595(3), 311.720, 311.990(11) (Michie 1998); La. Rev. Stat. Ann. § 32.9 (West 1998); Michigan Senate Bill 546, P.A. 107 (1999) (signed July 7, 1999) (eff. date 90 days after closing of 1999 legislative session); Miss. Code Ann. §§ 411-41-71, 411-41-73 (1998); Missouri Senate Substitute No. 3 for House Bills Nos. 427, 40, 196 and 404 (1999), to be codified at Mo. Rev. Stat. § 565.300 et seq.; Mont. Code Ann. § 50-20-401, as amended by 1999 Mont Laws 479; Neb. Rev. Stat. Ann. §§ 28-326, 28-328, 71-148(15) (Michie 1997); N.J. Stat. Ann. §§ 2A:65A-5 to -7 (West 1997); N.D. Cent. Code §§ 14-02.6-01 to 14-02.6-03; Okla. Stat. tit. 21, § 684 (1998); R.I. Gen. Laws §§ 23-4.12-1, 23-4.12-2, 23-4.12-3, 23-4.12-4 (1998); S.C. Code Ann. §§ 44-41-85, 16-1-90(F) (Law Co-op 1997); S.D. Codified Laws §§ 34-23A, 34-23A-32 (Michie 1998); Tenn. Code Ann. § 39-15-209 (1997); Va. Code Ann. § 18.2-74.2 (Michie 1998); Wis. Stat. §§ 895.038, 940.16 (1997); W.Va. Code §§ 33-42-3, 33-42-8 (1998). Three other states have attempted to target intact D&X in statutes using different language. *See* Kansas Stat. Ann. § 65-6721 (1998); Ohio Rev. Code §§ 2919.15 to 2919.19, 2307.51, 2305.11(C) (1997); Utah Code Ann. § 76-7-310.5 (1999)

[11]Partial-birth legislation has been the subject of numerous final federal district and state trial court decisions. *Summit Med. Associates, P.C. v. James*, 984 F. Supp. 1404 (M.D. Ala. 1998) (question certified to Ala. S. Ct.); *Little Rock Family Planning Services, P.A. v. Jagley*, No. LR-C-97-581, 1999 WL 753928 (8th Cir. Sept. 24, 1999) (Ark.); *Planned Parenthood of Alaska v. State of Alaska*, No. 3AN-97-6019 CIV (Super. Ct. Mar. 13, 1998); *Planned Parenthood of S. Ariz. v. Woods*, 982 F. Supp. 1369 (D. Ariz. 1997); *A Choice for Women v. Butterworth*, 54 F. Supp. 2d 1148 (S.D. Fla. 1998); *Midtown Hosp. v. Miller*, 36 F. Supp. 2d 1360 (N.D. Ga. 1998) (approving consent order), *dismissed*, No. 1:97-CV-1786-JOF, by order entered Sept. 9, 1998); *Weyhrich v. Lance*, No. 1:98-CV-

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Partial-birth type statutes have now been the subject of several final federal circuit court decisions. *Hope Clinic v. Ryan*, Nos. 98-1726, 99-2528, 99-2533, 1999 WL 974098 (7th Cir. Oct. 26, 1999) (Ill. and Wis.); *Carhart v. Stenberg*, Nos. 98-3245NE, 98-3300NE, 1999 WL 753919 (8th Cir. Sept. 24, 1999) (Neb.); *Planned Parenthood of Greater Iowa. v. Miller*, No. 99-1272SI, 1999 WL 753770 (8th Cir. Sept. 24, 1999) (Iowa); *Little Rock Family Planning Services, P.A. v. Jagely*, No. 99-1004EA, 1999 WL 753928 (8th Cir. Sept. 24, 1999) (Ark.); *Summit Med. Associates v. Pryor*, 180 F.3d 1326 (11th Cir. 1999) (Ala.) (limited to Eleventh Amendment issue); *Women's Med. Prof. Corp. v. Voinovich*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 523 U.S. 1036 (1998) (Ohio).

Moreover, there are presently five partial-birth abortion cases pending on appeal in federal courts of appeals. *Rhode Island Med. Society v. Whitehouse*, — F. Supp. 2d — , 1999 WL 683846 (D. R.I. 1999), *appeal docketed*, Nos. 99-2095, 99-2141 (1st Cir. 1999) (proceedings stayed pending decision of a writ of certiorari in this case, Nov. 23, 1999); *Planned Parenthood of Central N.J. v. Verniero*, 41 F. Supp. 2d 478 (D. N.J. 1998), *appeal docketed*, No. 99-5042 (3d Cir. argued Nov. 19, 1999); *Richmond Med. Ctr. for Women v. Gilmore*, 55 F. Supp. 2d 441 (E.D. Va. 1999), *appeal docketed*, Nos. 98-930, 99-2000 (4th Cir. 1999); *Causeway Med. Suite v. Foster*, 43 F. Supp. 2d 604 (E.D. La. 1999), *appeal*

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[11](...continued)
117 (D. Idaho Oct. 12, 1999); *Hope Clinic v. Ryan*, 995 F. Supp. 847 (N.D. Ill. 1998); *Planned Parenthood of Greater Iowa v. Miller*, 30 F. Supp. 2d 1157 (S.D. Iowa 1998); *Eubanks v. Stengel*, 28 F. Supp. 2d 1024 (W.D. Ky. 1998); *Causeway Med. Suite v. Foster*, 43 F. Supp. 2d 604 (E.D. La. 1999); *Evans v. Kelley*, 977 F. Supp. 1283 (E.D. Mich. 1997); *Intermountain Planned Parenthood v. Montana.*, No. BVD-97-477 (Mont. Dist. Ct., June 29, 1998); *Carhart v. Stenberg*, 11 F. Supp. 2d 1099 (D. Neb. 1998); *Women's Med. Prof. Corp. v. Voinovich*, 911 F. Supp. 1051 (S.D. Ohio 1994); *Planned Parenthood of Central N.J. v. Verniero*, 41 F. Supp. 2d 478 (D.N.J. 1998); *Rhode Island Med. Society v. Whitehouse*, 1999 WL 683846 (D. R.I. Aug. 30, 1999); *Richmond Med. Ctr. for Women v. Gilmore*, 51 F. Supp. 2d 441 (E.D. Va. 1999); *Planned Parenthood of Wis. v. Doyle*, 44 F. Supp. 2d 975 (W.D. Wis. 1999).

docketed, No. 99-30324 (5th Cir. 1999); *Eubanks v. Stengel*, 28 F. Supp. 2d 1024 (W.D. Ky. 1998), *appeal docketed*, No.98-6671 (6th Cir. to be argued Dec. 15, 1999).

Two courts of appeals have now addressed the partial-birth abortion issue on the merits: the Eighth Circuit (represented by the present case) and the Seventh Circuit, *Hope Clinic v. Ryan* and *Christensen v. Doyle*, — F.3d —, 1999 WL 974098 (7th Cir. 1999) (upholding partial-birth abortion bans from Illinois and Wisconsin). The Fourth Circuit has also addressed the statutory construction issue in interlocutory orders staying the preliminary and permanent injunctions of a Virginia district court against implementation of the Virginia partial-birth abortion ban on the basis that as properly construed the statute bans only a procedure no plaintiff alleged doing, i.e., intact D&X. *Richmond Med. Ctr. for Women v. Gilmore*, 144 F.3d 326 (4th Cir. 1998), *aff'd*, 183 F.3d 303 (4th Cir. 1998) (staying prelim. injunction); *Richmond Med. Ctr. for Women v. Gilmore*, No. 98-1930(L) (4th Cir. Sept. 14, 1999) (order staying permanent injunction).

This issue is now ripe for this Court's resolution.

III. A Partial-Birth Abortion Case Should Be Accepted for Review Due to Conflict Between the Circuits.

A partial-birth abortion case is now ripe for review because there has been extended record development (with full trials in the Nebraska and Wisconsin cases), full development of the arguments through extended briefing, and a conflict between the Eighth Circuit (this case) and the Seventh Circuit. *Hope Clinic v. Ryan* and *Christensen v. Doyle*, — F.3d —, 1999 WL 974098 (7th Cir. 1999) (upholding partial-birth abortion bans from Illinois and Wisconsin).

CONCLUSION

For the foregoing reasons, Amici Curiae request the Court to accept one or more partial-birth abortion cases for review, requesting in the present case only review of the two questions set out at the beginning of the present brief.

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No. 99-830

Supreme Court, U.S.
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In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

JOINT APPENDIX VOLUME I, PAGES 1 TO 240

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RELEVANT DOCKET ENTRIES

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6/12/97	1	COMPLAINT with request for trial at Lincoln with request for TRO and preliminary injunction. . . .
	–	
6/17/97	7	MEMORANDUM AND ORDER: by Judge Richard G. Kopf granting motion for temporary restraining order. . . .
	–	
8/14/97	19	MEMORANDUM AND ORDER: by Judge Richard G. Kopf re: request for a preliminary injunction is granted as provided herein; Defendants are . . . enjoined from enforcing LB23 against Plaintiff regarding his performance of D&X abortions on nonviable fetuses. . . .
	–	
2/17/98	36	PRE-TRIAL ORDER
	–	
7/2/98	46	MEMORANDUM AND ORDER: by Judge Richard G. Kopf that judgment will be entered by separate document . . . for the Plaintiff and against the Defendants; LB23 is declared unconstitutional as provided and that Defendants are permanently enjoined from enforcing LB23 against the Plaintiff, his patients and others similarly situated. . . .

8/10/98	49	JUDGMENT: by Judge Richard G. Kopf entered for the Plaintiff and against the Defendants . . . as applied to Dr. Carhart, his patients and others similarly situated, LB23 is declared unconstitutional. . . .
8/12/98	56	NOTICE OF APPEAL: by Defendants Donald Stenberg, Gina Dunning and Charles Andrews from District Court decision re: Judgment [49-1]. . . .

United States Court of Appeals for the Eighth Circuit

9/2/98	Civil Case Docketed. . . .
4/19/99	ARGUED AND SUBMITTED IN ST. LOUIS. . . .
9/24/99	JUDGMENT: . . . The judgment of the lower court is AFFIRMED in accordance with the opinion. . . .

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

LEROY H. CARHART, on behalf of himself and his patients obtaining abortions, Plaintiff, vs. DONALD STENBERG, in his official capacity as Attorney General for the State of Nebraska; MIKE MUNCH, in his official capacity as County Attorney for Sarpy County, and as a representative of all County Attorneys in Nebraska; DEB THOMAS, in her official capacity as Director of Regulation and Licensure of the Nebraska Department of Health and Human Services, Defendants.	4:97CV3205 July 17, 1997 9:00 a.m. Lincoln, Nebraska

VOLUME I,
TRANSCRIPT OF PRELIMINARY INJUNCTION
PROCEEDINGS, HELD BEFORE THE
HONORABLE RICHARD G. KOPF,
UNITED STATES DISTRICT JUDGE

* * *

[Henshaw, Direct]

[By Mr. Gans]

[p. 49] Q I'm going show to show you what's been marked as Exhibit 9, and I would like you to turn your attention to the 1996 report. If you could look at the first page of that report?

A Yes.

Q On page one, what does the report say about how many abortions were performed during 1996 in Nebraska?

A There were 5,214 abortions reported as being performed in Nebraska in 1996.

Q And if you could now turn to table 5 which I believe is the table concerning methods of abortion?

A Yes.

Q What does the State indicate about the methods used by physicians terminating pregnancies in Nebraska?

A Well the large majority of abortions are done by suction curettage. That's the method primarily used for first trimester abortions. Some were reported as sharp curettage. These are most likely D & E's. The Nebraska reporting form does not have a category for dilatation and evacuation, which is D & E, and in my opinion, physicians doing those would very likely count them as sharp curettage. Some might check off suction curettage. There are none reported as being by induction; that is, saline installation or Prostaglandin [p. 50] installation, even though those categories are on the reporting form. My assumption is that none were done. There were 49

reported as other, and it's my understanding that those are probably primarily – either Mifepristone or Methotrexate abortions which is a method of medically inducing a very early abortion before eight weeks.

Q So in your professional opinion, what is the procedures used after the first trimester?

A It would be D & E in Nebraska.

Q Okay. Are you familiar with the data collected by the CDC?

A Yes, I am. I use the data all the time.

Q All right. I'm going to show you Exhibit 17 ask you to identify that.

A This is a table from the 1992 Abortion Surveillance Report that's published by the Centers for Disease Control.

Q And what does the data on that chart indicate about the methods used to terminate pregnancies nationwide.

MR. SMITH: If I could, just for clarification, what exhibit are we on?

MR. GANS: 17.

MR. SMITH: Thank you.

THE WITNESS: This table cross-tabulates the method of abortion by weeks of gestation. It shows that at all points in gestation, curettage, which would include D & E, is [p. 51] the most common method used to perform abortions.

BY MR. GANS:

Q And is the data in that chart generally consistent with the data in Nebraska?

A Yes, it is, in that, as I just testified, either all or just about all of the second trimester abortions in Nebraska are done by D & E. This table shows that nationally, 86%, approximately, of abortions past 15 weeks are done by D & E, and that induction is fewer than 10%.

Q I would like to show you –

THE COURT: Counsel, let me just bring to your attention, we had a discussion before this witness testified about the difference between D & E and D & X. It is unclear to me, when your witness uses the term D & E, whether he intends to distinguish that procedure as we were talking about it, or whether he means to talk about it more generally. D & E can be included, intact D & E, as your colleague refers to. It's unclear to me what your expert means.

MR. GANS: Okay. I will try and clarify that.

BY MR. GANS:

Q In either the CDC data or the Nebraska data, do they – Is there a differentiation between the sort of more traditional D & E procedure or the variant that we have been discussing as intact D & E?

[p. 52] A The intact D & E or the D & X, I think, normally would be included under the D & E category here which would be curettage, so there is no way to

quantify how many of the D & X abortions are done based on the statistics collected by the State or the CDC.

* * *

[p. 53] Q Okay. I'm going to ask you some questions about the impact of the act on abortions performed in Nebraska after the first trimester. I would like you to assume that as a result of the act, abortions in Nebraska stopped performing D & E's, either the more traditional D & E procedure involving dismemberment, or the variability where the fetus is removed intact, stopped doing both, both variants of the D & E. What in your professional opinion would be the impact on women in Nebraska seeking second trimester abortions?

MR. SMITH: I'm just going to object. There is not [p. 54] adequate foundation.

THE COURT: What foundation is lacking?

MR. SMITH: Frankly, I think the assumption makes his opinion irrelevant. I mean, I don't think it's properly a subject of expert opinion at that time.

THE COURT: That's the foundation that's lacking.

MR. SMITH: Yes.

THE COURT: The objection is overruled, and I will understand his testimony to be based on inferences drawn from statistics. Go ahead. The witness may answer.

THE WITNESS: That would pose a serious barrier to women in Nebraska seeking second trimester services. The options would be to try to find a hospital

where induction abortion could be performed or travel out-of-state or continue the pregnancy, and in Nebraska, hospital services are not readily available and as we saw.

MR. SMITH: Your Honor, I would object to his opinion that hospital services are not readily available as no foundation for that opinion.

THE COURT: Would you like to lay additional foundation on that issue?

BY MR. GANS:

Q Have you ever done any research about the availability of abortions in hospitals in Nebraska?

A As I mentioned, our survey of all abortion providers in [p. 55] the country, of course, covers Nebraska, and we get a – from that survey a count of all hospitals in the country that we have actually been able to locate that – where abortions are performed.

THE COURT: The objection is overruled. You may continue.

BY MR. GANS:

Q And based on the data you collected, how many hospitals in Nebraska reported performing abortions?

A Our last survey was conducted in 1992. At that time, three hospitals in Nebraska reported any abortions at all, and those hospitals reported very few. In fact, together, they reported doing 25 abortions in the State which is what, only four-tenths of a percent of the abortions performed in the state in that year.

Q And of those three hospitals that performed abortions, do women go directly to the hospital to obtain an abortion?

A On our questionnaire, we had the question, can a woman arrange directly with the hospital, or must she go through an attending physician. Two of the three hospitals said that she must go through an attending physician. The third did not answer the question, so based on that, I conclude that a woman could not arrange directly with the hospital to have an abortion under present circumstances.

Q And of the three hospitals that you found performed [p. 56] abortions, did any of the hospitals limit the circumstances in which a physician could perform abortions?

A We didn't ask that question, but one of the respondents wrote onto the form that abortions are done only for therapeutic reasons.

Q Based on this data you collected, do you have an opinion about whether a woman would be able to obtain a second trimester abortion in Nebraska if D & E's, including both the traditional and the intact variety, were unavailable as a result of the act?

A Well, nationally, about 10% or more of abortions are done during the second trimester. If that were applicable to Nebraska, that would be over 500 abortions during the second trimester. If you just look at abortions past 14 weeks, it would be, maybe, on the order of 300 abortions. Given the fact that at least in 1992, only 25 abortions were performed in hospitals, I think it would

be difficult for most women who needed that service to be able to obtain it from a hospital.

Q Have you ever conducted research on the difference in cost between a D & E performed in an outpatient clinic and an induction performed in a hospital?

A Yes.

Q And how did you conduct that research?

A In our 1992 survey, nonhospital facilities were asked [p. 57] the charges for abortions at 16 weeks and 20 weeks, and then as a supplement to the survey, we did a telephone survey of some small sample of hospitals nationally where we knew abortions were being done and asked the same question, questions, so with that information, we were able to calculate the average charge in facilities, nonhospital and hospital facilities, of abortions done at 16 weeks and 20 weeks.

Q And what conclusions did you reach?

A We concluded that a clinic abortion at 16 weeks cost in the range of 500 to $600, whereas a hospital abortion done by installation, that is usually saline or Prostaglandin, averaged $2,246. At 20 weeks, the clinic abortion cost 900 to a thousand dollars, and the hospital abortion cost about $2,400.

Q And do you have an opinion as to whether the cost differential would affect women's access to second trimester abortions if D & E's were unavailable as a result of the act?

A There is evidence that the cost of abortion services proposes a barrier to women who need the service,

so I would conclude from that that if the cost were much higher, that it would tend to prevent some women from obtaining the service.

Q You've stated earlier that the – You stated earlier that if D & E's, were unavailable as a result of the act, if they were going to get an abortion in Nebraska, would have to [p. 58] seek an abortion in a hospital. What other impact would that have on their access to the service?

A Well, the other option is to travel out-of-state for a second trimester abortion.

Q Let me rephrase it. Would that have any option on the time of the gestational age when they would obtain an abortion?

A I'm assuming that if they could get an abortion in the hospital, it would probably be more difficult than it is now to simply go to a clinic, so that – and it would be more expensive, so the time it would take to arrange to have the abortion would be greater than it is at present. First of all, we know from studies of the reasons people delay having abortions, that the time taken to make the arrangements is a major reason that people are delayed to the second trimester; that is, the time to get together the money and to find out where to go and actually make the appointments and get there, so my conclusion would be that even if they were able to find the service, that there's a good – that for a fair proportion of the women, their abortion would be later than it would have been otherwise.

Q Would that delay have an impact on the health risks for women on second trimester abortions?

A There are many studies that show both complication rates and mortality rates from abortion increase with each [p. 59] additional week of gestation past around eight weeks, so additional delay would increase the risk of both morbidity and mortality.

Q And starting with mortality first, what would be the increased risk?

A Well, say, you were delayed from 13 to 15 weeks to 16 to 20 weeks. One group to the other, the mortality is about three times as great at 16 to 20 weeks as it is at 13 to 15. It's still not high. It's still, at 16 to 20 weeks, no higher than childbirth, but it's much greater than it is earlier in gestation. Sadly, your complications, we've calculated that the rate of complications increases by about 20% for each additional week of gestation from about eight weeks on.

Q And you testified now about three obstacles; one, availability of hospitals; two, the costs; and three, delay. Would some women in Nebraska be unable to overcome these obstacles and be forced to carry to term?

A Well, we know now that there are numbers of women who are unable to get abortion services at all because of lack of access, so it stands to reason that if you increase the barrier, that will cut off an additional group of women from having abortions.

Q You stated earlier that if D & E's were unavailable as a result of the act, some women might have to go out-of-state [p. 60] to obtain an abortion, is that correct?

A That's right.

Q And if a woman had to travel out-of-state to obtain an abortion in Nebraska, where could she go in the surrounding states?

A I checked our data on the surrounding states. The places she could go are Iowa City, Iowa; Kansas City; Wichita, Kansas; Minneapolis; or Denver.

Q And how far would she have to travel to each of these places?

A Well, it's in the hundreds of miles, depending on where in Nebraska she's coming from, of course.

Q And in your opinion, what would be the effect of forcing women to travel to these other states?

A We know that travel distance has an impact even on first trimester abortions. For these abortions, the impact would be greater because the D & E procedure, after maybe 14 weeks, usually requires either two days, or at later points in gestation, three days, so the woman would either have to make the trip twice or three times or stay overnight at the – in the city where she had the – or where the clinic existed, so yes, I think that would be a significant additional barrier.

Q And would you need to travel to the other states for some women to carry to term?

A Undoubtedly, there are some women who would not be able [p. 61] to maneuver that and to get to the other states.

* * *

[p. 63] BY MR. GANS:

Q So far we have been examining a type of situation in which D & E's were unavailable in Nebraska relative to the act. Do you have an opinion as to the effect on women seeking second trimester abortions in Nebraska, the physicians could perform both the intact and the dismemberment variety beginning at 19 weeks LMP through the use of fetal injection to cause fetal demise?

A Obviously, most women who have second trimester abortions have them before 19 weeks, so it would mean that most of the women would be forced to wait until 19 weeks before they could end their pregnancies, and that, of course, has the same effects. That's a delay. It would have the effects I've already discussed.

* * *

[p. 64] THE COURT: Counsel, you may inquire.

CROSS-EXAMINATION

BY MR. SMITH:

Q Dr. Henshaw, would your opinions be different if LB 23 did not, in fact, prohibit D & E's?

A Almost everything I said was based on the assumption that D & E's would be banned.

Q Okay. So the answer to my question is – yes, your opinions would be different?

A Yes.

Q And have you read the Legislative Bill 23?

A Yes, I have.

Q You've read the definition of partial-birth abortion in that?

A Yes, I have.

Q And does that definition use the term D & E?

A No, it doesn't.

Q Does it use the term dilation and extraction?

A No.

Q Does it specifically use any medical terminology for medical abortion procedure?

A Not as I recall.

Q Are you aware that the United States Supreme Court recently affirmed a state statute which proscribed anyone from doing an abortion who is not a physician?

[p. 65] A Yes, I am.

Q Have you done any studies on the effect of state regulations that require only physicians to do abortions?

A No, I haven't.

Q Would you expect that there would be an effect on the cost if only physicians can do abortions rather than physicians and physician's assistants?

A I think there would be a minor effect. Physician assistants can only function under the direct supervision of a physician, so the physician must be present or at least supervising the physician assistant.

Q Are you aware that under the laws of the State of Nebraska, a physician only has to be present 20% of the time for his physician assistant's duties?

A No, I'm not.

Q When you were using the terminology D & E, or in answering questions referring to D & E, you meant dilation and extraction procedures, is that what –

A Yes.

Q What's your understanding of what that procedure is?

A Excuse me. Dilation and evacuation.

Q I'm sorry. What was your understanding? That's why I asked the question. What was your understanding of the procedure?

A It's generally any procedure using instruments to end [p. 66] the pregnancy after either 12 or 14 weeks, depending on your definition.

Q Does the definition, or at least the context, in which you were using it, have as an element the intent to remove a part of the fetus from the uterus while it's alive?

A Well, the intent is to end the pregnancy by removing the fetal parts. Often, the operator knows the fetus is alive when he or she begins removing the fetal-parts. Beyond that, I can't talk about whether that is intent under the statute or not, but there is an intent to remove fetal parts that are living parts.

Q Well, you would agree that your understanding of D & E would simply involve using instruments to remove fetal parts from the uterus?

A That's right.

Q Do you still have Exhibit 7 in front of you, sir? That's the AMA report. If you do, I would ask you to just turn to that.

A Yes.

Q And just portions of the report I'm going to refer to and ask you if you agree or disagree with what it states. If you would, on the first page of Exhibit 7, line 35 through 36, it says, "AGI collects data directly from abortion providers."

A Yes, that's correct.

[p. 67] Q You understand the report to be AGI refers to the Alan Guttmacher Institute?

A Yes, it does.

Q So your institute does collect data directly from the abortion providers, is that correct?

A Yes, it does.

Q And on line 38 on the same page, it says, "However, AGI does not collect data on gestational age," is that correct?

A That's generally true. We actually, in our survey, we ask how many abortions the provider did the past 12 weeks, and we ask the gestational limit of the abortions done in the facility, so that statement isn't completely

true. The meaning of it is that we would rely on the CDC data on the number of abortions at each gestational age rather than try to calculate our own from our own survey.

Q If you would turn to the last page of Exhibit 7, or I'm sorry, the last page, it's page number 11, the last page. If you would turn to page number 11 of Exhibit 7?

A Yes.

Q And line 11, the last sentence of that full paragraph, it states, "However, more research on major complication rates associated with various procedures and by gestational age is needed before any confirmed conclusions about the relative safety and procedures can be made." Do you see that statement correct?

[p. 68] A Yes.

Q Do you agree or disagree, or do you have a basis to agree or disagree? I phrased that wrong. Let me ask you first, do you agree or disagree with that statement?

A Well, I think it's a question of which procedures are being referred to here. If it's, for example, it's well demonstrated that laparotomy – excuse me – hysterotomy is more dangerous than other abortion procedures. If you are referring to installation versus D & E, or D & E versus D & X, I would agree with that statement.

Q And when you use the term installation, would that be synonymous with an induction procedure?

A For the purposes here, yes. Induction could – That term could be used to refer to very early abortion

and medical abortion very early, but in the second trimester, most induction abortions would be installation, but not all, not all.

Q And continuing on page 11 of line – of Exhibit 7, the very last sentence says, "More systematic research is needed on complications and complication rates associated with various types of abortion procedures at 13 weeks of gestation and beyond." Do you agree or disagree with that statement?

A Yes, I think more research would be very useful.

Q And that's the business you're in is the research business, is that correct?

[p. 69] A Yes.

Q Now, also on Exhibit 7, on page 7, line 29?

A Yes.

Q Says, "Since the 1970's, vacuum aspiration, also referred to suction curettage, has been the most common procedure used to induce abortion in the first trimester," and then it has, in parenthesis, from the 6th through the 12th week of gestation. Do you agree or disagree with that statement?

A No, I agree with that.

Q And if you would, turning to the Exhibit 9, the 1996 Nebraska Statistical Report of Abortions, on page number four?

A Yes.

Q Table 5?

A Yes.

Q And that reflects at least the 5,161 abortions in Nebraska in 1996 were by the suction and curettage method?

A Yes.

Q And it shows a percent of 99%?

A There is – Yes.

Q And have you looked at the statistical reports for the previous years that the Nebraska Department of Health issues?

A I have looked at them briefly.

Q Would you agree, I mean, they'll state on their face, [p. 70] but would you agree as general principle that those reports would reflect that the suction curettage method of abortion has been the method reported as performed consistantly in the high 90%?

A I think that high 90% would include some second trimester abortions where probably a combination of sharp curettage and suction were used. As I mentioned, there is no line on the form for D & E, so the person doing a D & E ordinarily uses both sharp and suction curettage. Some of those are probably reported as both suction and sharp. You'll notice that the total is 5,764 which is much larger than the number of abortions performed which is 5,214.

Q Now, Dr. Henshaw, do you – do you or the Alan Guttmacher Institute have any affiliation or association with the Center for Reproductive Law and Policy?

A No.

Q Do you have or have you ever had any affiliation with Planned Parenthood?

A Yes.

Q What is that? Would you just explain what it would be.

A We are a special affiliate of Planned Parenthood. One of the meetings that is – that we participate in their pension plan. We see some funding from Planned Parenthood, something like 10 to 15% of our funding primarily for our Washington office.

[p. 71] Q Does that mean that your personal pension depends upon some funding from Planned Parenthood?

A No.

Q What does it mean?

A It means that we have shared a pension plan. The funding for our pensions come from our own organization which is independent of Planned Parenthood.

Q Have you personally been on the board of directors for Planned Parenthood?

A No.

Q Have you been on the board of directors for the Abortion Federation?

A The National Abortion Federation, yes.

Q And when were you on the board of directors for that?

A From around 1990 to 1996, something around then. Not '96, '95, '90 to '95 with them. It's on my CV.

Q And what does that organization, what is its purpose and function?

A Its purpose is twofold: To help abortion facilities provide services and to preserve access to abortion services for women.

Q And you understand that the plaintiffs' counsel in this case, they are hired or employed by the Center for Reproductive Law and Policy, correct?

A Yes.

[p. 72] Q And is that, is the Center for Reproductive Law and Policy, is that located at 120 Wall Street in New York?

A Yes it.

Q Where is the Alan Guttmacher Institute located?

A We're at the same address.

Q Now, are you familiar with the federal legislation on partial-birth abortion?

A Somewhat.

Q Do you know whether or not the Center for Reproductive Law and Policy has been involved in any activities lobbying or opposing that legislation?

A I don't have firsthand knowledge of it.

MR. GANS: Objection; relevance.

THE COURT: Pardon me just a moment.

MR. GANS: Objection; relevance.

THE COURT: Overruled. You may answer.

THE WITNESS: I don't have firsthand knowledge of their lobbying activities. I believe they are opposed to the legislation.

BY MR. SMITH:

Q Do you agree that you cannot make accurate judgments on what might happen in the future based on what happened in the past?

A That's a very general question. Sometimes you can make an accurate judgment of the future from the past. Sometimes [p. 73] you can't.

Q Well, you would have testified –

THE COURT: We aren't here to debate George Santianna's –

BY MR. SMITH:

Q Well, you did testify in the Eastern District of Michigan in the case filed there by Dr. Evans against the attorney general, correct?

A Yes.

Q And would you agree that you were asked the following question, and you gave the following answer: The question: "Do you think that you can make accurate judgments about what might happen in the future based on what happened in the past?" And your answer was, "No, I wouldn't say accurate, no." Would you agree?

A In that context, I would stand by that answer.

Q And would you agree that you also testified in that case that not too much of my work involves predictions. It's more descriptions of what has happened.

A Yes.

Q And that, in fact, is what your work primarily is, is describing what has happened historically?

A That's right.

Q You don't purport to be a fortune teller?

A That's right.

[p. 74] Q You would agree it's not a static world, and that the market changes in response to market conditions, what the laws are in at any particular time?

A That, again, is a very general question. Sometimes yes and sometimes no.

Q I know what I wanted to ask. Does your statistical research, at least on induction procedure in the second trimester abortion, have you done studies on whether those are primarily performed in or out of hospitals?

A They almost always involve hospital care. There are a few physicians who will begin the procedure outside of a hospital. As far as I know, they either always or almost always seek hospital care for the woman during the labor and delivery.

Q And just so we're on the same wavelength, by an induction, we are talking about a procedure in which the physician would induce labor prematurely for purposes of an abortion?

A That's correct.

Q Now, as far as what your studies have shown statistically, and if you know, as far as the percentages of inductions performed in hospitals versus outside of hospitals, such as in clinics?

A As I say, I'm not aware of any substantial number of induction procedures being done in clinics. I don't know [p. 75] that it's ever done actually.

Q Have you done any research to determine why that is the case?

A I've heard physicians talk about it. That's the extent of my knowledge.

Q But as far as actually doing any statistical studies or gathering any, what you would consider legitimate emperical data, have you done that?

A Actually, that question is on our survey that's going to be sent out shortly, but in the past we have never asked that question, mainly because I wasn't aware that it was actually an issue. I had never heard of induction abortions being done outside of hospitals.

Q At least from your research, would your research indicate that hospitals have better facilities, in general, than clinics?

A I think you have to specify better facilities, what you mean by that.

Q More equipment, protocols, staffing to address concerns of maternal health than a clinic would?

A I think that in many cases, clinics are better equipped to provide high-quality abortion service because they are focused on that particular service. The staff is specifically trained for it, and the equipment needed for it is there. There are many hospitals where abortion patients [p. 76] are cared for by people who deliver babies, do all kinds of other things, and may not understand the special problems of abortion patients, may be even unsympathetic to them.

Q Do you actually have any data to support what you just said, or is that your speculation?

A I have data to show that most hospitals where abortions are done do very few abortions, so it's impossible that the staff would be specialized in abortion services in that circumstance.

Q And have you any data or statistics to support your statement as far as the caring attitude of hospital staff?

A I would have to do some research. I can't think of studies right now, but they might exist.

Q Are you aware of any studies, data that would explain why hospitals would do inductions versus dilation and evacuations, or at least why they would primarily do inductions rather than dilation and evacuations?

A I think they primarily do dilation and evacuation. Most hospital abortions, to my knowledge, are done by D & E.

Q It's just when we are talking induction procedures, those are primarily done in a hospital but not in a clinic?

A That's right.

MR. SMITH: Nothing further.

THE COURT: Counsel, you may inquire.

MS. WALZ: No questions. Thank you.

[p. 77] . . . BY THE COURT:

THE COURT: Doctor, before you step down, I have a couple of questions. Would you look at Exhibit number 7 and page 8 of that exhibit?

THE WITNESS: Yes.

THE COURT: I'm going to be referring to the last paragraph. In that last paragraph, describes the D & X [p. 78] procedure and it states, and I quote, "According to the American College of Obstetricians and Gynecologists, intact D & X is comprised of the following elements: Deliberate dilation of the cervix, usually over a sequence of days, instrumental conversion of the fetus to a crippling breech, breech extraction of the body, accepting the head, and partial evacuation of the intracranial contents of a living fetus to affect vaginal delivery of a dead but otherwise intact fetus." Now, when I speak of D & X, that's what I mean?

THE WITNESS: Yes.

THE COURT: Okay: Are there good numbers about – that would tell us how many D & X as opposed to D & E procedures are being conducted nationally?

THE WITNESS: There are no good numbers. The only way to get numbers is to actually try to find the doctors doing them and estimating how many they do. To

my knowledge, there are only a few doctors nationally who do large numbers of D & X abortions.

THE COURT: I take it from that answer that the center that you represent then, has not endeavored to distinguish between the two for purposes of data collection?

THE WITNESS: It's only recently become an issue at all. In our new survey, we are going to be asking that question, but I hadn't heard the term in 1992, and it wasn't [p. 79] a political issue. Even today, it isn't really a medical issue, but it is a political issue.

THE COURT: What do you mean by that?

THE WITNESS: Well, in my opinion, the D & X is one type of D & E. There are many types. The only reason to single that out for special interest is because it has special political significance.

* * *

[Carhart, Direct]

[p. 81] BY MR. HELLER:

Q Please state your name for the record.

A LeRoy Harrison Carhart.

Q What is your profession?

A I'm a physician.

Q Before I begin asking you questions, I just want to provide you with copies of some of the exhibits that I'm going to ask you questions about. I'm giving you copies of Exhibits 7, 11, 12, and 16. If you could look at Exhibit 16. Do you have that one there?

A Yes, sir, I do.

Q Can you identify that document?

A It's my curriculum vitae.

Q Does that document accurately characterize your experience and background?

A Yes, sir, it does.

Q Can you tell me your educational background?

A Undergrad, I have a Bachelor's in accounting and finance from Rutgers University in New Jersey. I have further Bachelor, B.S. work from Saint Mary's University in Texas. That was in transferring. Completed my pre-medical training in 1970 – I'm sorry – 1965. Medical school was at Hahnemann Hospital and University in Philadelphia in 1973. My internship was with United States Air Force in Washington, D.C. I was in a medical, rotating internship, and my [p. 82] residency was at Hahnemann Hospital, and finished at one of the affiliation of Hahnemann, my last two years at Atlantic City Medical Center.

Q Have you been licensed to practice medicine?

A Since 1973 in Pennsylvania. I'm sorry. Since 1974 in Pennsylvania.

Q Do you currently have – Are you currently licensed to practice medicine in any states?

A Yes, sir, I am.

Q Which states are you licensed?

A I will go through the list of these here. Currently Nebraska, Pennsylvania, New Jersey, Iowa, Ohio, Indiana, Kansas, and Wisconsin.

Q Are you currently practicing medicine in Nebraska?

A Yes, sir, I am.

Q Would you describe your practice here in Nebraska?

A I run a family practice type of environment, general medical practice with a specialized abortion facility practice.

Q How long have you had that practice?

A Since 1985.

Q Since 19 – I will withdraw that. How long have you been practicing in Nebraska?

A I practiced since 1978. Excuse me. From 1978 until 1985 as a member of the United States Air Force.

[p. 83] Q In 1996, how many abortions did you perform in Nebraska, if you know?

A Approximately 800.

MR. SMITH: I'm sorry. Was it '96? Just for clarification, I wasn't sure if he asked '86 or '96.

THE COURT: My understanding was 1996.

THE WITNESS: That was my understanding, 1996.

BY MR. HELLER:

Q At what gestational ages of pregnancy do you perform abortions?

A We will – From the time of a woman's confirmation that she is pregnant, through fetal viability.

Q Can you give – Well, how do you measure gestational age?

A We use ultrasound for all of our patients and compare that with their menstrual dating.

Q If you were to try to quantify a particular gestational age, do you do it in a number of weeks?

A Yes, sir.

Q And where are the number of weeks measured from?

A From the first day of the last menstrual period.

Q So again, going back to the question about what gestational age is, what would be approximately the earliest gestational age you would perform an abortion?

A The earliest we've done is two weeks and two or three [p. 84] days. I'm sorry. Well, probably – three weeks from the last menstrual period. As soon as the woman has had a positive pregnancy test, we have done women one day after that which would be, if they conceive on the 14th day, which we assume, probably five to seven days post that date.

Q Do you use the same method of abortion for all the abortions you use, or do you use different method?

A Different methods.

Q Let's start with – Well, do you use different methods, depending on the gestational age or on other factors?

A Gestational age is one of the factors, but there are medical factors that can influence a decision also.

Q Tell me which methods you use in the overall methods.

A Overall, we use Methotrexate and Mifepristone – Methotrexate and Misoprostol combination for very early terminations. We use RU 486 and Mifepristone – RU 486 which is Mifepristone with Misoprostol for women that are under eight weeks from the sixth – or actually, from the fourth week to 14, 15 weeks. Occasionally, we will use suction, vacuum aspiration. At about the 12th or 13th week, we usually use curettage with vacuum aspiration up through the 15th, 16th week, after that 16th week, generally, it's a dilatation and evacuation procedure, and after the 18th week, we will use – Actually, that's not true. After the 16th week, we will use a partial form of induction to speed the [p. 85] process.

Q Just so I'm clear about this, when you are talking about a partial form of induction, does that mean you use –

A The old –

Q Well, could you tell me what that means?

A The old or classical definition of induction would include the saline or Prostaglandin installation into the uterine cavity, and then waiting for fetal demise, and then using drugs to cause the uterus to dilate or the cervix to

dilate and the uterus to contract. We don't do the installation portion of that. We do use Prostaglandin to aid in cervical dilatation, and we do use drugs that cause the uterus to contract.

Q Are those drugs used to augment surgical procedures, or are they used standing alone to terminate pregnancy?

A They are used to augment the surgical procedures.

Q Are the only procedures you do that do not involve surgery the ones you mentioned, Methotrexate and RU 486?

A They normally don't involve surgery, and the study that we're a part of, approximately three-tenths of 1% have used surgery as a backup.

Q Let's focus now on the second trimester abortions. By that, I mean abortions after 14 weeks from the LMP I'm going to use LMP as abbreviation for the first day of the woman's last menstruation period, is that all right?

[p. 86] A Yes, sir.

Q For second trimester abortions after 14 weeks, are you aware of methods, other than the ones you use, that can be used to perform those abortions?

A Yes, I am.

Q What methods are they?

A The saline or Prostaglandin induction and hysterotomy come to mind, being the most common, and hysterectomy is occasionally used.

Q What fees do you charge at different – Excuse me. I will withdraw that question. What fees do you charge for abortions?

A Okay. Can I use my notes, or how do you –

THE COURT: Certainly.

THE WITNESS: Our medical procedures are $350, and we are assuming a cash payment, if that's all right with the Court. The medical procedures would be $350. A surgical procedure from the fourth week, which is two weeks after conception through the beginning of the 12th week or 11 weeks, six days, our price is $275. Twelfth and 13th week, it goes to 375. The 14th and 15th week, it goes to 425, and the 16th through the 17th week, it goes to $600. Each of those procedures, the patient has an option to add IV sedation to her procedure if she elects to do that. There is an additional charge of $60 through the 17th week. After the [p. 87] 18th week, we have factored that in because we use – I have sedation for almost all of our patients unless there is a reason not to or the patient has a desire not to.

BY MR. HELLER:

Q What are your fees for after 18 weeks?

A The 18th and 19th week, our fees go to $895. The 20th and 21st week, $1,250; the 22nd through the 23rd week, six days, are $1,850; and 24th week and above would be by a personal discussion or arrangement with the patient.

Q You indicated earlier that you do abortions through the point of fetal viability?

A Yes, sir.

Q If you see a woman who needs an abortion or wants an abortion after viability, do you refer her elsewhere?

A I will. If there is no medical indication, I will refer her elsewhere. If she has a – If she herself has a medical indication or the fetus has a medical indication of not being viable, then we would not refer.

Q Where do you –

A Not necessarily refer her.

Q Where do you refer her?

A I generally refer to George Tiller in Wichita, Kansas.

Q Do you refer women to other abortion providers in Nebraska?

A No, sir, I do not.

[p. 88] Q Do you receive referrals from other physicians in Nebraska?

A Yes, sir, I do.

Q Can you estimate approximately how many different physicians within Nebraska have referred women to you for abortions?

A No. I have never kept that list, but it's – I can state probably well over 15 or 20 that I'm aware of, maybe much greater than that. I don't – I couldn't –

Q One of the documents I handed you, which is one that is not marked as as an exhibit, is a copy of Legislative Bill 23. Do you see that there? I hope I did give it to you.

A Everything I have is marked as an exhibit.

Q All right. Well, then, I'll have to give you one. Have you read this document before?

A Yes, I have.

Q I would like to call your attention to this version of it, page four of the document. There is a subsection 9 that contains a definition of partial-birth abortion. Do you see that?

A Yes, sir.

Q First, is partial-birth abortion a medical term?

A I have not seen it discussed in medical discussions other than in response to the bills that have been before the federal and local state courts, so I don't think on pure [p. 89] physician-medical basis, there is not a term partial-birth abortion.

Q For example, are you aware of any medical textbooks that use that term?

A I do not believe there are any textbooks that use that term.

Q Looking at the second sentence of that subsection 9, do you see the part that says for purposes of this subdivision, the term partially delivers vaginally a living and unborn child before killing the unborn child means deliberately and intentionally delivering it to into the

vagina a living, unborn child, or substantial portion thereof for the purpose of performing a procedure where the person performing such procedure knows will kill the unborn child and does kill the unborn child?

A Yes, sir.

Q I want to focus your attention on the term substantial portion. The portion that says a living, unborn child, or a substantial portion thereof. What is your understanding of what substantial portion means?

A I do not understand what substantial portion is.

Q What are the range of possibilities it could mean to you?

A I think it could mean any identifiable part of the fetus. I think it could mean the umbilical cord. I think it [p. 90] could mean an extremity, I think it could mean a portion of an extremity, a foot, a toe, a hand, a finger. I think it could mean a portion of the skull, if it's a face-first presentation, where the forehead protrudes from the cervical os before anything else comes out.

Q Also in that same sentence, there is the term living, unborn child. What is your understanding of what that phrase means?

A I think medically, it has no meaning. I think politically, it has an inflammatory meaning.

Q Well, let me – Let's focus on the term living. What is your understanding of what – Let me ask you a different question. Someone said to you a living fetus, what is your understanding of that term?

A It's a fetus that is viable, that has a heartbeat, that has – it is undergoing normal genetic or normal embryonic development.

Q By viable and what you just said, do you mean after the point of viability?

A No. I mean, at that given moment, not that it – I don't necessarily mean that it's going to go on and live. We don't know that, but a pregnancy, I think at 10 minutes after conception, you have two cells that are living or one cell as they combine.

Q I want to return now to your summary of the methods you [p. 91] use to perform abortions and ask you to describe those in some detail one-by-one. Let's start with the early procedures you do. Let me start with the one you described, Methotrexate and –

A Methotrexate and Cytotec or Mifepristone.

Q How does that procedure work?

A That is a procedure that's done on very early patients. It's usually – and there is currently a study that's being proposed to do tablets, but it's usually an injectable form of the drug Methotrexate is given after you have done an ultrasound to ascertain the exact dating of the pregnancy. Usually, the injection is given in one of the large muscles of the body, and after a period of five to seven days, the patient returns for the second ultrasound to confirm the fetus is no longer living, and at that point she uses the Cytotec tablets. We are currently using four 200-milligram tablets vaginally to promote or to cause induction, if you wish, to cause the fetus to expel the

pregnancy – I'm sorry – to cause the uterus to expel the pregnancy.

Q And then you also described the method using RU 486?

A RU 486 is a drug Mifepristone which we're currently using in a clinical setting, a clinical experimental setting, that's being conducted through the University of Rochester. Consists of one tablet of – one tablet of RU 486 and Mifepristone taken by the patient in the clinic on the first [p. 92] day. On the third day, the patient, and that, again, is after an ultrasound to confirm gestational dating. On the third day, the patient would insert the tablets Cytotec tablets at home vaginally, returning on the fourth day for an ultrasound to confirm that the abortion is complete.

Q In both of those cases, if the abortion is not complete, what do you do?

A In the case of the Methotrexate, we would, on the seventh day, if the fetus is still viable, give a second dose of Methotrexate and have the patient again return in a week. There have been some reports of people doing up to four doses. We have not done that. We have elected after the second dose, if the fetus is still living, to go ahead and do a surgical aspiration abortion.

Q Putting aside, then, these two methods of RU 486 and Methotrexate, you indicated you also do a suction aspiration?

A A vacuum aspiration.

Q A vacuum aspiration. Can you describe what you do in a vacuum aspiration procedure?

A Again, and I didn't go into the preoperative portion of both of these, the medical and the surgical, but we have a rather extensive patient advocate session where we describe the procedure completely and review the patient's options. We do laboratory testing to show her that they are a candidate, if they don't have other medical reasons that [p. 93] would preclude doing an abortion at that time. We do ultrasound to confirm gestational dating, and subsequent to that, we use a local anesthetic to numb the cervix. We use a series of progressively increasing dilating rods to enlarge the cervix, and then we use the plastic, in my case, I use plastic, but there are metal cannulas available to insert through the cervical os, and when attached to a vacuum machine, cause the contents of the uterus to pass through that tube. Following that we use a sharp curettage to clean the uterine wall, and we reaspirate following that, and then the patient goes to recovery.

Q What would be the latest stage in pregnancy that you would use the procedure you just described?

A In the 14th to 15th week. Most of the time by the 15th week, it doesn't work. I always start that way in 14 or 15 weeks, but most of the time, you have to use a mechanical forcep to actually grasp the fetus and remove it.

Q Now, talking about the ones where you are doing only that procedure, the vacuum aspiration procedure, do you use ultrasound while you're conducting the surgery?

A Yes, sir, I do.

Q Can you describe for the Court what ultrasound is?

A It's an adaption of the sonar developed by the Navy in the 1930's to find the different densities of substances, usually in comparison with a known substance. In our case, [p. 94] we are looking for air, fluid, and the main substance we are comparing to is water. The other fluids are fetal tissue, fetal cartilage, and we are comparing the densities of that to actually graphically present a picture of the fetus on a television screen.

Q When you're doing the vacuum aspiration procedure, can you see the television screen that displays that graphical image?

A Yes, sir, at all times.

Q And does it show only the fetus or a larger picture?

A It shows approximately a five, five-by-six-inch area of the pelvis. If the fetus is large enough, it's only the fetus. If it's an early pregnancy, then you would see surrounding. You can move it to see any portion of the pelvis you want or any portion of the body, you can do ultrasound. You can use the same machine to do ultrasound on testicles, ultrasounds on breasts, on the heart, on the liver. It just shows you a given area.

Q In a vacuum aspiration procedure, when you begin the procedure, are you able to determine whether the fetus is alive?

A Yes, sir. We do that – Well, we do it because the patient needs to know if she is coming to the clinic with a fetus that is not alive, most – It's a monetary interest to

the patient because most of the insurances will cover a D & C [p. 95] that remove a dead, terminated pregnancy that spontaneously terminated, so we feel it's important that the patient be aware of that, and we also will often let the patients go, especially if they are on [sic] medicaid where they can receive this charge for free at a local hospital through their own provider, we'll allow them to go back and see that provider. I think it's really in their best interest to know if the fetus is alive or dead. If the fetus is alive and it's within our gestation, again, we would continue.

Q As you're doing the vacuum aspiration procedure, can you determine – Well, first, do you remove a substantial portion of the fetus vaginally during vacuum aspiration?

A We remove all the fetus either intact or just dismembered.

Q How do you decide, or how is it determined whether it's intact or dismembered?

A It's whatever, when it comes through the tube. I have no – I have no governing effect on that.

Q What I mean is, can the whole fetus come through the tube, through the suction tube?

A If the fetus, if you are using – if we feel the fetus may warrant using a 9 cannula, a fetus was a little bit smaller than that, it could come through intact without disruption.

Q Could you describe for the Court, please, I don't know [p. 96] what this terms means either. What is a cannula?

A The cannula is the tube the plastic curette that we actually insert into the uterus through the cervical os tube to end the pregnancy.

Q Does that come in different sizes?

A They come in one millimeter size differences from four millimeters, that we carry in our clinic from five millimeters up through 16 millimeters.

Q So if that tube is sufficiently – If it's larger than the fetus, the fetus may just be sucked out in one piece?

A That's correct, and during the very early terminations, if you use the manual aspirators which are available, then you're using a size six or seven aspirator or a three- to four-week pregnancy, they almost invariably come out intact.

Q At what point in that vacuum aspiration procedure is the fetus killed or does the fetus die? Does it happen before you begin the procedure?

A No.

Q Can you identify the point at which it dies?

A Well, we use a – in our bottles that collect the specimens, we use a tissue that's – I mean, we use a substance that detoxifies blood which kills all living cells, so once it arrives in that bottle, I would say that it dies very rapidly, but I think in the journey through the tube and through the tubing and the machine, not knowing if or when it [p. 97] died, I do know of physicians that have testified and physicians that have stated, and I have seen films of – or where they have done the studies, and they

can actually show a viable fetus at six or seven weeks when it's outside of the body.

Q Again, by viable fetus, you mean –

A Actually, currently living fetus.

Q Rather than able to survive.

A It's absolutely not able to survive, but for a few seconds it could have a heartbeat or have other functions outside of the body.

Q Do you have an opinion about whether the partial-birth abortion law that we're talking about covers the type of procedure you're describing, the vacuum aspiration procedure?

A I think it absolutely does because the entire fetus has to be a substantial portion of the fetus, and it is coming through the tubing alive in many circumstances.

Q Let's talk about the type of procedure you do after you can no longer do the vacuum aspiration procedure. Tell me how that procedure works.

A The initial phases, initial portions are all the same up through the lab work, the ultrasound, and the actual injections to numb the cervix. At that point, we would still dilate as we would for a mechanical procedure up to, depending on the gestation, up to approximately 16 to 17 [p. 98] millimeters in diameter. At that point, we would put an osmotic dilator, which is a small piece of, in actuality, of seaweed that has been sterilized and prepared medically so that it was sterile. We would coat that with an antibiotic solution or antibiotic ointment, place those in the cervix. At that point, the patient would wait

generally 12, sometimes up to, depending on the gestation, from 12 to 72 hours before we would complete the abortion, and by completing the abortion, the patient would go home, or if they lived more than – We would like them to be within an hour, but we require them to stay within at least two hours of the clinic so if there was an emergency they could get back. When they return, we remove the laminaria. If the dilation is adequate, we would go ahead and rupture the membranes and then remove the fetus mechanically. Following the fetal removal – the fetus, removal of the fetus and the placenta, we would vacuum aspirate to make sure no tissue fragments are left on the uterine wall, and we would also use a sharp curettage to clean the uterus, and then the patient would go to recovery. If the patient were over 19 weeks, or if the patient did not dilate well, we might remove the laminaria we had put in and place new laminaria, or we might simply add a few additional laminaria and use Cytotec tablets to help the uterus start to dilate. It's a Prostaglandin.

Q You mentioned at one point laminaria. And I just wanted [p. 99] to be clear for the record, can you tell me, is laminaria the same as the seaweed?

A Laminaria japonica is the type we use.

Q When you described the woman leaving your office after she has a laminarius inserted and staying within one or two hours, is she able to carry on her normal activities during that time period, or are there specific restrictions?

A There are restrictions. We would restrict them, we would suggest restrictions. I'm not sure they are always

carried out. We would like them not to have any sexual activity. We would like them not to engage in any physically demanding strenuous work. We ask them to try to keep driving to a minimum. In fact, we ask them not to drive at all because they are also receiving medications to help with pain relief, so they are instructed not to drive at all. We do have – We have had patients that would go back to work and work the rest of that day and work part of the next day before they came in if their work was desk work.

Q When you do what you described as the mechanical removal of the fetus for these later abortions, is that also done with ultrasound?

A Yes, sir, it is.

Q So again, you can see graphically the picture of the fetus and surrounding area?

A Yes, sir.

[p. 100] Q Tell me in more detail how you go about mechanically removing the fetus.

A Once we're certain that we have adequate dilation, we either use the vacuum aspirator to rupture the membranes or use a forcep to rupture the membranes. And occasionally, the membranes that surround the fetus and hold the bag of water will spontaneously rupture before the patient gets into the procedure room. Once the membranes have been ruptured, anything over 15 weeks, our intent is to try to remove the fetus as intact as possible, and we do that mechanically with either a Beier forcep which is a – looks like a specialized pair of pliers,

long-handled that can reach inside of the uterus to grasp a portion of the fetus and to bring it out of the uterus.

Q At that time when you begin that procedure, let's say, for example, at 16 or 17 weeks of gestation, do you know whether the fetus is alive when you begin the procedure?

A Up through – up through the 19th week, it's invariably alive.

Q How can you determine that it's alive?

A Well, on our – We use ultrasound. We always do a fetal heart rate before we do a second trimester procedure. It's documented on our laminaria forms of the fetal heart rate, at the beginning and also at the end of each time the patient comes into the procedure room through the serial dilations, [p. 101] and then we again check fetal heart rate prior to starting the final removal of the fetus.

Q You indicated that your intent is to try to remove the fetus as intact as possible?

A Yes.

Q Can you tell me why that is your intent?

A Well, I think statistically from the literature I've read, and from my comment talking with other people that do the later abortions, the number one – not the number one – probably the number three factor in lowering maternal complications is to eliminate sharp fragments, either pieces of long bone or pieces of skull fragments, from passing through the cervical os without some kind of covering or protection. When you remove

them intact, the bones are covered by the fetal tissue. It's less traumatic to the cervix. I think the other two important things that we do to reduce complications is to try to evacuate the contents of the brain directly outside of the uterus because I believe that one of the second, probably most common cause of maternal death or maternal complications, is DIC or disseminated intravascular coagulopathy. Fetal brain tissue is thought to be one of the most seriously implicated factors that cause maternal DIC, that fetal brain tissue being absorbed through the uterine wall into the blood stream causing her own coagulation factors to stop working, and I [p. 102] think the most serious or the most common cause of maternal death or complications, severe maternal complications today is amniotic fluid embolus, and that's our intent to drain the amniotic fluid before we start the procedure in order to use the evacuation procedure to hopefully remove all the amniotic fluids before we remove the fetus.

Q You indicated that you try to remove the contents of the – I think you said of the skull or of the brain?

A Remove the brain or the contents of the skull, yes.

Q And I think you said outside the uterus. I wasn't sure. At what point were you trying to do that during the procedure?

A I try to do it when the skull, when the skull is reachable through the cervical os.

Q Where is the rest of the fetal body at that point?

A It may be entirely behind the fetus inside the uterus, or it may be entirely out of the uterus in the

vaginal cavity, depending on the way the fetus was in presentation.

Q So do I understand you that if the fetus happens to be feet first, that's how you would remove it?

A Yes.

Q And if it happens to be head first, you would remove it that way?

A That's correct.

Q What specific ways do you use to decompress the skull? [p. 103] I will rephrase it. Can the skull fit through the cervix?

A If you have adequate dilation, yes, the skull can fit through the cervix. The skull is the largest dieter [sic, diameter] object that has to come through the cervix. I think that you reduce complications to the mother by having – I think – well, first of all, you reduce them by having enough dilation to do the procedure, but as little dilation as possible also helps to reduce other maternal complications such as incompetent cervix at a later date, so we would like to have the cervix large enough for the tissues of the fetus to pass through, but the fetal skull is often twice that big in diameter, so we would like to reduce the diameter of the skull to the point that it can come through that – the os, too, and our dilation, normally, that's what our dilation – We are looking for a dilation that's large enough to allow the pelvis and allow the parts to pass through compressed, granted, but not fragmented.

Q How would you compress the skull?

A Compress the skull using forceps, but if you compress the skull using forceps totally, then the skull will rupture at some point. Some of the tissue will come out of the uterus, but most of it will go in behind, if the skull – if the fetus is feet first, most of it is going to rupture through the upper portion of the skull and go into the uterine and be in the uterine cavity at which point it can be [p. 104] absorbed.

Q So is there an alternative to crushing the skull that you use?

A We use a sharp object to either tear or perforate the skull in some position so that we can put a cannula in and remove the cranial contents.

Q So you both you would use both alternatives, crushing the skull sometimes, sometimes evacuating the contents of the skull?

A Yes, sir.

THE COURT: Pardon me, counsel. It's now about 12:00 o'clock. Give me a sense of how much longer you will be. I'm simply, I guess, asking directly whether now would be a good time for our break.

MR. HELLER: I think it would be a fine time. I think I probably have approximately an hour of additional questions.

THE COURT: All right. Let me hear from the defendants. Would now be a good time for our break?

MR. SMITH: Yes.

THE COURT: All right. Let's take about an hour and 15 minutes and return at 1:15. Let me see

counsel at the bench, please. Pardon me, Doctor. You may step down, sir.

(Side bar)

THE COURT: Does anybody have any security concerns [p. 105] over lunch?

MR. HELLER: My concern is only that there were protesters out front as we approached this morning. They were rather vocal in their remarks to Dr. Carhart, "Murderer," things like that. So I'm just a little bit concerned about his leaving the courthouse and who is going to be out there when we leave.

THE COURT: Okay. Anybody else have any security concerns?

MR. GRASZ: I don't.

THE COURT: Okay. You want to go to lunch someplace outside the building, I take it?

MR. HELLER: Well, yeah, probably nearby. Is there a place nearby?

THE COURT: I'll tell you what I do. I order lunch in from a deli place, and my office can order for all of you if you want to do something like that. Otherwise, I don't know where people normally eat. Let me ask my law clerk. I don't know if you go to lunch.

MS. REMPE: There are several places close by within the block here. There is a pizza place.

MR. HELLER: Any of those would be fine. We can probably walk.

THE COURT: Is your preference to go out?

MR. HELLER: I think probably it is for a little [p. 106] while.

THE COURT: Okay. Would any of you have any objection if I had somebody from the marshal service take Dr. Carhart out through the east [sic] entrance? We have a garage entrance. Would any of view [sic] any problem with that?

MR. HELLER: No, we have no problem [sic] that. I think he would probably feel a little safer if we did that.

THE COURT: We can't provide you security outside the building, but we can give you an entrance.

MR. HELLER: The rest of us can meet him at the outside, I suppose.

THE COURT: Well, you all can go with the marshals, all of you can go, but coming back is going to be a problem because I can't have a marshal sitting there, and so you're going to have to come back through the east side.

MR. HELLER: There was – I'm not sure if it was a marshal or security guard out front.

THE COURT: There is, and there should be extra police protection out there, but folks are entitled to do what they want on the sidewalk, so if you exercise this, my point is you're going to have to come back through the east door.

MR. HELLER: That's fine.

THE COURT: I will ask you, Ms. Rempe, to take counsel and anybody who wants to go and parties to the

[p. 107] marshal service and tell them I would like to have one of the CSO's or the marshals let them go out the north door. In fact, you can take them out the north door. Why don't you just take them out?

MS. REMPE: Okay.

THE COURT: Do you know where the north door is?

MS. REMPE: We'll be going down the elevators.

THE COURT: Take them down the back. Why don't you walk down?

MS. REMPE: The stairs?

THE COURT: Yeah. That will get you out to the north door. You'll have to come back in the east door.

MR. HELLER: Thank you, Your Honor.

THE COURT: We'll see you at 1:15.

(Recess from 12:05 to 1:17 p.m.; all parties present)

THE COURT: Counsel, you may proceed.

BY MR. HELLER:

Q Thank you, Your Honor. Dr. Carhart, before we took a recess for lunch, we were talking about the procedure you used in the second trimester or procedures you used in the second trimester, and you were talking about a procedure that involved an effort to remove the fetus intact and then reducing the size of the skull so it could come through the cervix. You had identified one advantage of that procedure was something having to do with bones or bone fragments?

[p. 108] A Yes, sir.

Q Are there any other advantages to that procedure that you believe exist?

A Other than the bone fragments, the tissue fragments itself, the skin also, when you macerate the skin, it also has a propensity to release anticoagulants in the maternal circulation. Just the less instrumentation, if you can grab one part or two parts and remove the fetus, then you're not making multiple attempts to go back in the uterine cavity. Even with ultrasound, you're still partially blind. You've got two axis to see. You don't have a third so you can grasp a portion of the uterine wall, you can do damage to maternal structures.

Q Do you have an opinion about whether performing an intact D & E is safer than performing a D & E that is not intact?

A In my practice, the way I do it, I think it's much more safe.

Q Are there times when you don't remove the fetus intact?

A Yes, sir.

Q Can you tell me about that, when that occurs?

A That occurs when the tissue fragments, or frequently when you rupture the membranes, an arm will spontaneously prolapse through the os. I think most – Statistically, the most common presentation, we talk about the forehead or the [p. 109] skull being first. We talked about the feet being first, but I think in probably the great majority of terminations, it's what they would

call a transverse lie, so really you're looking at a side profile of a curved fetus. When the patient – the uterus is already starting to contract and they are starting to miscarry, when you rupture the waters, usually something prolapses through the uterine, through the cervical os, not always, but very often an extremity will.

Q What do you do then?

A My normal course would be to dismember that extremity and then go back and try to take the fetus out either foot first or skull first, whatever end I can get to first.

Q How do you go about dismembering that extremity?

A Just traction and rotation, grasping the portion that you can get ahold of which would be usually somewhere up the shaft of the exposed portion of the fetus, pulling down on it through the os, using the internal os as your counter-traction and rotating to dismember the shoulder or the hip or whatever it would be. Sometimes you will get one leg and you can't get the other leg out.

Q In that situation, are you, when you pull on the arm and remove it, is the fetus still alive?

A Yes.

Q Do you consider an arm, for example, to be a substantial portion of the fetus?

[p. 110] A In the way I read it, I think if I lost my arm, that would be a substantial loss to me. I think I would have to interpret it that way.

Q And then what happens next after you remove the arm? You then try to remove the rest of the fetus?

A Then I would go back and attempt to either bring the feet down or bring the skull down, or even sometimes you bring the other arm down and remove that also and then get the feet down.

Q At what point is the fetus – does the fetus die during that process?

A I don't really know. I know that the fetus is alive during the process most of the time because I can see fetal heartbeat on the ultrasound.

THE COURT: Counsel, for what it's worth, it still is unclear to me with regard to the intact D & E when fetal demise occurs.

BY MR. HELLER:

Q Okay. I will try to clarify that. In the procedure of an intact D & E where you would start foot first, with the situation where the fetus is presented feet first, tell me how you are able to get the feet out first.

A Under ultrasound, you can see the extremities. You know what is what. You know what the foot is, you know, what the arm is, you know, what the skull is. By grabbing the feet [p. 111] and pulling down on it or by grabbing a knee and pulling down on it, usually you can get one leg out, get the other leg out and bring the fetus out. I don't know where this all the controversy about rotating the fetus comes from. I don't attempt to do that. I just attempt to bring out whatever is the most proximal portion of the fetus.

Q At the time that you bring out the feet in this example, is the fetus still alive?

A Yes.

Q Then what's the next step you do?

A I didn't mention it. I should. I usually attempt to grasp the cord first and divide the cord, if I can do that.

Q What is the cord?

A The cord is the structure that transports the blood, both arterial and venous, from the fetus to the placenta and from the placenta back to the fetus, and it gives the fetus its only source of oxygen, so that if you can divide the cord, the fetus will eventually die, but whether this takes five minutes or 15 minutes and when that occurs, I don't think anyone really knows.

Q Are there situations where you don't divide the cord?

A There are situations when I can't.

Q What are those?

A I just can't get to the cord. It's either high above the fetus and structures where you can't reach up that far. [p. 112] The instruments are only 11 inches long.

Q Let's take the situation where you haven't divided the cord because you couldn't, and you have begun to remove a living fetus feet first. What happens next after you have gotten the feet removed?

A We remove the feet and continue with traction on the feet until the abdomen and the thorax came through

the cavity. At that point, I would try – You have to bring the shoulders down, but you can get enough of them outside, you can do this with your finger outside of the uterus, and then at that point the fetal – the base of the fetal skull is usually in the cervical canal.

Q What do you do next?

A And you can reach that, and that's where you would rupture the fetal skull to some extent and aspirate the contents out.

Q At what point in that process does fetal demise occur between initial remove – removal of the feet or legs and the crushing of the skull, or I'm sorry, the decompressing of the skull?

A Well, you know, again, this is where I'm not sure what fetal demise is. I mean, I honestly have to share your concern, Your Honor. You can remove the cranial contents and the fetus will still have a heartbeat for several seconds or several minutes, so is the fetus alive? I would have to say [p. 113] probably, although I don't think it has any brain function, so it's brain dead at that point.

Q So the brain death might occur when you begin suctioning out of the cranium?

A I think brain death would occur because the suctioning to remove contents is only two or three seconds, so somewhere in that period of time, obviously not when you penetrate the skull, because people get shot in the head and they don't die immediately from that, if they are going to die at all, so that probably is not sufficient to

kill the fetus, but I think removing the brain contents eventually will.

THE COURT: Counsel, once again, and just so we're all playing on the same score card, so-to-speak, I suppose that we can debate what fetal demise means, and I understand the doctor's statement. It might be helpful to talk about lack of heart function, lack of brain function to the extent you all think that's important. I think that will clarify the record. Those are typically the normal indicia of life.

MR. HELLER: Certainly, Your Honor.

BY MR. HELLER:

Q I think you've said that brain function may continue for a few seconds. I'm sorry. Not brain function, heart function may continue for a few seconds after the skull is decompressed, is that correct?

A Right.

[p. 114] Q And then the heart would stop, is that correct?

A Eventually, yes. The heart, you can take the heart out of, you know, medical school, remove the heart from dogs. They have done studies on this back into the 30's and 20's, remove the heart and do studies on the heart for several minutes on hours if you infuse it with oxygen and saline and keep the heart alive. The rest of the fetus is not innately necessary to keep the heart alive. It's just as long as the heart is going to beat until it runs out of oxygen and the cells die on its own.

Q How soon after you begin decompressing the contents of the skull would you say that the brain function ceases?

A This would be purely conjecture. I don't know of any instruments that are even made to measure that. I certainly wouldn't have the availability of any of those.

Q Certainly, the brain function doesn't continue after you have done that?

A No, the brain function doesn't, but University of Florida just reported several brain transplants from fetal tissue several days after the death – after the termination of the pregnancy into humans, and they are showing response to that living fetal tissue, so the cells may not function as a brain, but that doesn't mean the cells are not living.

Q Well, in terms of brain function, the brain has ceased to function very quickly after you begin the – removing it?

[p. 115] A I guess I don't know that anybody can tell you what the brain does in a fetus. I mean, we can find some brain waves. There is no good evidence that they represent anything. All the movements in the fetus from – do not correlate to brain waves, but the movements the fetus does are thought to be unintentional and more reflex, reflexive and probably at the spinal cord level rather than the brain cord, the brain tissue level, so I don't know how to answer that.

Q Now, are there situations where you set out not to do – to remove the fetus intact but to remove it by dismemberment, or is your intention always to –

A I think my intention after the 16th week is always to remove it intact. I think that my actual success in doing that is probably, up through the 19th week, less than five or 10% that actually come out totally intact.

Q Why is that?

A I think because of the softness of the tissue where the tissue is easily fragmented, and again, I don't feel the need to push the arm back up or try to turn the fetus to get the feet out first. I think you have to take advantage of whatever presentation you have and reduce the size of the fetus as much as possible and remove it. I'm sure you could do more dilation, and you could remove all of them intact if that were your goal, but I don't – I'm looking for a solution that's the best all around for the mother. I mean I [p. 116] –

Q When you are doing a D & E that involves dismemberment, where does the dismemberment occur; in other words, do you insert instruments into the uterus and dismember the fetus inside the uterus, or do you dismember it in some other way?

A Well, we insert one instrument inside the uterus, grab a portion of the fetus and pull it through the cervical os. The dismemberment occurs between the traction of – I'm sorry – between the traction of my instrument and the counter traction of the internal os of the cervix. I suppose you could put two instruments in the uterus and try to dismember it. I think that would be very dangerous.

Q So the dismemberment occurs after you pulled a part of the fetus through the cervix, is that correct?

A Exactly. Because you're using – The cervix has two strictures or two rings, the internal os and the external os, and you have – that's what's actually doing the dismembering. It's like who is pulling the cat's tail. If you are holding it and the cat's pulling it, something has to pull the other way. Otherwise, if you drag a string across the floor, you'll just keep dragging it. It's not until something grabs the other end that you are going to develop traction.

Q When we talked before or talked before about a D & E, that is not – where there is not intention to do it intact, [p. 117] do you, in that situation, dismember the fetus in utero first, then remove portions?

A I don't think so. I don't know of anyone that – I don't know of any way that one could go in and intentionally dismember the fetus in the uterus. If you grab an extremity and twist it, you can watch the whole fetus just twist. It takes something that restricts the motion of the fetus against what you're doing before you're going to get dismemberment.

Q When you pull out a piece of the fetus, let's say, an arm or a leg and remove that, at the time just prior to removal of the portion of the fetus, is the fetus alive?

A Very often, yes, sir.

Q And after that, when does fetal demise occur in that type of abortion?

A I think the fetus is going to lose blood the same as an adult would or a child would if it loss an extremity, but how fast that is going to happen, I don't know that I can comment on. I don't know any way you could study

that, and I don't know how many – how many minutes or how many hours the fetus could continue to lose this blood. The fetal blood supply is certainly much greater than the adult or the children's blood supply because they have got a blood supply both in the fetus and in the placenta, so it's going to take a considerable amount of blood loss before the fetus is going to, you know, [p. 118] have an insufficient amount to profuse. I don't think there is any way to determine that. I mean, we could – I could do it by watching the monitor. I'm not – There has been one case in New York that a physician lost his license over - when he removed the arm of the fetus, and that fetus eventually went on and was born-as a living child with one arm, so I don't think you can say that necessarily will cause death.

Q Well, when you do a procedure and you remove an arm, what do you do next?

A Just continue removing whatever else you can get a hold of.

Q At some point during the removal of portions of the fetus, does the fetus die? In other words, you remove, let's say, a leg or an arm, then you remove some other portion of it. At some point, is the fetus – Does the fetus undergo demise, do you think?

A As a unit –

Q Well, let's talk about it as a unit, a functioning unit.

A Well, as a unit, I would think there is some point that the loss of the extremity is going to be so great that the fetus will die. That may well take longer, though, for

all heart functions to stop. We are only talking, for some of these patients, a procedure that lasts four to five minutes. Heart function certainly can continue more than four to five [p. 119] minutes.

Q Have you ever removed a portion of a fetus and observed heart function on ultrasound?

A While we are removing it?

Q After removing it or during.

A I have never done an ultrasound on the fetus afterwards, no, but while the fetus is in the canal and you're removing the fetus through it, we can still see fetal heart activity with extensive parts of the fetus removed.

Q Do you ever try to induce fetal demise before beginning surgery?

A Yes.

Q Under what circumstances do you do that?

A I usually try to do this on all of my patients after the 20th week of menstrual gestation.

Q What method do you use to induce fetal demise?

A I use an ultrasound guided much like amniocentisis and intrafetal – or hopefully an intracardiac fetal injection of Digoxin and Lidocaine.

Q What do those substances do?

A Both of those substances reduce and stop cardiac activity.

Q How long after administering those substances do you perform surgery?

A Normally not for 48 to 72 hours.

[p. 120] Q Is there an advantage to doing that? To –

A I feel multiple advantages. First of all, it's comforting for the woman to know that the fetus is already dead. I think that gives some mental – It's an end point to the procedure that she's not living with for two or three days. I think the second thing it causes is, there have been some very good studies of people that have divided the cord on fetuses and caused fetal demise and waited 24 to 48 hours for these patients to do the last part of the procedure, and the tissues become very soft, and they become very malleable, and the brain plates will overlap. You can do much less dilation. We have been keeping some numbers or we'll see an actual loss in measurements of the fetal skull up to two weeks over that 72 hours. We are supposed to get four, five or maybe even a six millimeter decrease in biparietal diameter because of the loss of water from the fetus and then from the loss of the mush, mush factor. I don't know what else to call it by the softness of the tissue that compresses just from the maternal contractions.

Q Why would you not use Digoxin and Lidocaine to induce fetal demise prior to 20 weeks?

A I have – I initially started doing it on everyone over 16 weeks. My findings were that it really was not that beneficial because in the 16- to 20-week time frame we're only waiting 12 to 24 hours to go on with the second part of [p. 121] the procedure so that, really, fetal death had occurred but not much a change to the tissue had occurred, and the risk, there was a trade-off with the maternal comfort from the fact the fetus was dead. There

is a trade-off of the great apprehension and fear that most women have of having an amniocentesis done, let alone when they know their fetus is going to die from it. There is a mental you know, most of my early patients. The later patients seem to be very thankful, but the patients in the 15-, 16-, 17-, 18- and even 20-week range are more afraid of – just were asking if they could avoid that. We finally, we'll do it if they ask us to do it. We sort of tell them it's available, but we don't normally do it.

Q Is there any medical reason not to do it earlier than 19 or 20 weeks?

A Yes, there is. The reason why saline induction was originally in the early 60's and the 70's were limited to after the 18th and 20th week. You have problems of perforating bowel, you have problems from needle penetration. As the uterus enlarges, it pushes all these structures out of the way, and there is less chance of causing maternal complications, but under that, before the 20th week, I don't necessarily – I don't think that is true. I think there is more likelihood of putting the needle through a loop of bowel or as the uterus is smaller, you have a much smaller target [p. 122] and you have more of a chance of getting the medication into the maternal circulation than you do into the fetal circulation.

Q Why is that?

A Well, we are using two drugs that are – is the maximum recommended dose for an adult woman of a hundred pounds, and that's why it's not toxic to her. If the entire amount of the drugs were injected into her blood stream, it would not be toxic, probably, if they had no other side effects, no other medical problems, so that's

why I use the dose that I do use. That dose is toxic to the fetus. But there is always a chance of getting into, say, the cord, getting into the placenta, or maybe even getting into the uterus itself, and as I said, we are dealing with a two-dimensional picture trying to, in our mind, to determine where the third dimension is, and if you get through the placenta, through the fetus into the posterior uterine wall, then the mother can get all of the side of effects from the Digoxin or all of the side effects from the Lidocaine.

Q Do you ever see patients who for whom those Digoxin and Lidocaine are medically contraindicated?

A Yes, sir. Patients who have seizure disorders, patients who have heart disease, possibly already on Lidocaine – already on Digoxin as a maximum level, they already have received the maximum dosage of that medication they can. You [p. 123] can't – I can't take the risk to use that medication for them.

Q And that would be even if they are after 20 weeks?

A Anytime, yes, sir.

Q So in those instances, you can't really induce fetal demise?

A No.

Q We were talking about intact D & E before. Have you ever had a patient request that the abortion be – result in intact fetus?

A I have, and I will tell them much the same as I tell the people that request that we we don't do that, is

that I will try to honor their wishes, but I can't compromise their safety and do something that is more dangerous in order to have that as the end goal.

Q What – And what – Have patients indicated to you their reasons for wanting it intact?

A We have patients that occasionally ask to have their fetus buried through a funeral parlor, to have services. Both people, I mean, even gestations where they know the that [sic] fetus is probably not going to be intact we have had them request that. Sometimes for genetic studies, when the entire, the entire amount of the deformities aren't known, we'll get requests from a physician, possibly, to have the fetus as intact as possible.

[p. 124] Q I want to refer you now – Do you have the exhibits there that I gave you?

A Yes, I do.

Q Exhibit 7, and if you would turn to page 8 of that exhibit?

A Yes, sir.

Q If you would turn to the last paragraph of that page, the paragraph states – Well, do you see the paragraph that begins with, "To minimize uterine or cervical perforation?"

A Yes, sir, I do.

Q If you could read that over and tell me whether you agree with it.

A Should I read it out loud or just read it?

Q You can read it to yourself.

A Okay. Can you repeat your question?

Q Well, let me ask you more specific questions. Do you agree that as this statement says, "That some physicians use a form of D & E that has been referred to in the popular presence intact dilation and extraction." Do you agree that some physicians do that?

A Yes, sir, I would.

Q Do you agree that they do it in part to minimize uterine or cervical perforation?

A Yes, sir, I would.

Q Do you agree that the D & X procedure may minimize [p. 125] trauma to the woman's cervix uterus and other vital organs?

A Yes, sir.

Q Earlier we talked about other second trimester procedures, and you mentioned inductions. You testified that you don't do inductions in second trimester. You do procedures earlier that might be called inductions. Why don't you do inductions in second trimester?

A Well, to do a classical induction would require – Well, first of all, it would require the patients to stay longer. An induction, you don't know where the end point is going to be. You're at the – at the, I guess, totally under the control of the cervix, when it's going to release. I had - An associate had a patient in one of our Omaha hospitals in '92 that was 19 weeks pregnant with – I'm sorry – a pregnancy with a 19-week gestation, was

severely, had severe fetal flaws, and their hospital would only allow induction. He attempted to induce her for a period of over a week. Subsequently, they ruptured membranes, and still, the patient did not deliver, and subsequently she ended up having hysterotomy and a total hospitalization of over two weeks. It's, to me, induction by itself is too uncontrolled. There is no finite end point, and women have reactions to the drugs. The number of people that you can't use for induction because of hypotension or heart disease or diabetes, it's a large segment of the population where it wouldn't be [p. 126] available to them.

Q Are you aware of physicians in Nebraska who perform abortions by induction?

A Yes, sir.

Q Where do they do that? At what facilities?

A The facilities I'm aware of are Bergan Mercy, University of Nebraska, and Methodist.

Q Methodist Hospital?

A Yes, sir.

Q If a woman wanted an abortion by induction, would you then refer her to one of those places?

A I couldn't refer her to the hospital in any of those instances. I can't refer her to the University of Nebraska because they are restricted. They can only do – they can only do terminations on women that have – that have pregnancies that are so severely flawed they cannot survive through delivery. And I strongly – I think I believe

strongly enough that induction is not or is actually contraindicated in abortions that I would not make the referral. I would tell them of the places or the people that they could see if they wished to pursue it on their own, but I would not make the referral.

Q If an induction does not result in termination of the pregnancy, what is done to complete the abortion?

A You have the option of either doing osmotic dilators and [p. 127] doing the abortion that we would classically do in the two or three-day setting, or the hysterotomy which is a C-section, but because of the fact that the uterus is not large enough, you can't do the safe C-section where it would be a low transverse C-section and allow the woman to have future pregnancies that she could deliver. You have to do a midline upper third incision into the uterus, and that condemns her to C-sections for all her future deliveries.

Q Are you aware of any induction being performed in outpatient clinics in Nebraska or in doctor's offices?

A I'm not.

Q Again, I'm talking about second trimester abortions.

A I'm not aware of any. I'm sure it's happening somewhere in the country. I think I know everybody in Nebraska that's doing abortions, and I'm not aware that any of them do them in their office.

Q Do you perform hysterotomies as a method of abortion?

A No, sir.

Q What about hysterectomy?

A No, sir.

Q Are you aware of any physicians in Nebraska who perform abortions by hysterectomy or by hysterotomy?

A Yes, sir. I know they have been done in Nebraska.

Q Do you have a copy of Exhibit, I believe, 11 or 12? Do you have either of those there?

[p. 128] A I have both 11 and 12.

Q If you could look at Exhibit 11, is there a cover page on Exhibit 11, or is it just one page?

A There are –

Q Three pages?

A Yeah, three sheets of paper. One is double-sided.

Q If you look at the second piece of paper, can you identify that?

A This is the current Nebraska State Department of Health reporting form.

Q Is that the form you use to report abortions?

A Yes, sir, it is.

Q Currently?

A Yes, sir.

Q Does that form contain a space on which you can indicate the method of abortion used?

A Yes, sir, it does.

Q Can you tell me what methods are listed there?

A Paragraph 14 says types of procedure performed that terminated pregnancy. Choose one. Suction curettage, medication-induced, specify. Dilatation and evacuation, sharp curettage, dilatation and excision, and other.

Q The one prior to other dilatation and excision, are you familiar with that as a procedure for doing abortions?

A No, sir, I'm not.

[p. 129] Q So do you when you do an intact D & E or what we have also called an D & X, how do you report that on this form?

A On this form, we are doing it under block number three.

Q What is block three?

A Dilatation and evacuation, D & E.

Q Which exhibit are we on on that?

A We were on page number 2 of Exhibit 11.

Q If you could now look at Exhibit 12?

A Yes, sir.

Q Can you identify that document?

A This is the form that was used, at least back through 1988, that I'm aware of in the State of Nebraska.

Q And did that form include a section where you could indicate the type of procedure used?

A Yes, sir, it does, under section 8a.

Q And what types of procedures are listed there?

A Suction curettage, sharp curettage, intrauterine saline installation, intrauterine Prostaglandin installation, hysterotomy, hysterectomy, and others.

Q Where on that form would you have indicated that you did either a dilatation and evacuation or a D & X abortion?

A Under suction curettage.

Q That's because that's the one that best fits?

A I think that's the one that fits the most.

Q On the newer form, is hysterectomy or hysterotomy listed [p. 130] as a method still?

A I don't believe it was. Just other, I think you would have to specify in there.

Q If you faced prosecution for performing any D & E procedure, whether the fetus was alive, what would the impact be on your patients?

A If, by facing prosecution, you mean if I could change my practice and not become prosecuted?

Q Let me rephrase the question. If you faced prosecution for performing D & E procedures, what would your options be?

A Okay. If I knew that I would be prosecuted if I did the D & E the way I'm doing it now, I would stop

doing them the way I'm doing them now. I think the options would be to probably stop doing abortions between the 7th week and the 18th week because I think that I would be totally safe doing the medical procedure where we're sure the fetus is dead before it is expelled, and I think I would be safe during fetal injection which I, in my own mind, I think I could safely bring down to the 19th week. In the hiatus between the 7th week and the 18th week, I think I would refer them to another state or tell them that they would need to delay, which I don't think I would recommend to anyone.

Q Now, if, instead, you knew that instead of removing the fetus intact or trying to remove the fetus intact, instead, you had to avoid doing that and just try to remove it in [p. 131] pieces, what impact would that have on your patients, the switch from intact procedure to the nonintact procedure?

A I think to intentionally bring sharp pieces of bone and sharp pieces of fetal skull plate through the cervical os is to ask for an increase in incidents in maternal complications, and I don't think that that is a wise judgment.

Q If you were –

A Can I add one? Then also by doing that, we go back to the other factors of having macerated skin tissue and macerated fetal brain tissue within the uterine cavity to be absorbed into the maternal circulation and cause, what is right now, the most common cause of maternal death of abortion and that is disseminated intravascular coagulopathy, or, fetal – I'm sorry – maternal – embryonic fluid aspiration embolus.

Q Aside from the risks associated with sharp bones and so forth and these other two, are there any other?

A Instrumentation.

Q What's that?

A The multiple instrumentation, the chances of tearing the uterus or perforating the uterus with the instrument each time you go back in.

Q If you were in that situation you described where you would stop doing abortions between 7 and approximately 19, 18 [p. 132] or 19 weeks, would your patients be able to obtain abortions by induction elsewhere in Nebraska that you know of?

A I don't believe so.

Q Would they be able to obtain abortions by hysterotomy in Nebraska?

A I don't know people that are doing these electively. I don't know of anyone in Nebraska that's doing these for elective abortions. They are doing them for, you know, for maternal or fetal indicated abortions.

Q Incidentally, in terms of your practice, do you know if there are other physicians in Nebraska who provide abortion services as late in gestation as you do?

A I believe I'm the only person in Nebraska that goes past 16 weeks, with the exception of Dr. Jerry Smith at University Hospital, but he is restricted to only doing abortions when the woman's life is in danger. Well, that's not true because he refers those to me. I can only do them when the fetus is so severely flawed that it cannot live to deliver.

Q Do you still have a copy of the statute LB 23 with you?

A Yes, sir.

Q If you could turn again to page four of that document, section 3, around line 17, do you see that?

A Yes.

Q That section states that, "No partial-birth abortion shall be performed in this state unless such procedure is [p. 133] necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including life-endangering physical condition caused by or arising from the pregnancy itself. Do you see that?

A Yes, sir.

Q Do you see women who need abortions for mental health reasons?

A I have referrals from other physicians for that, yes, sir.

Q And what are some of the mental health reasons for abortions?

A I have to go back and clarify that. I have not had any referrals in the state of Nebraska for mental health reasons. I'm sorry. I have had for other health, physical health reasons, but not actually mental health. However, I have had patients come to me and on their comment sheets at the end write that if this option had not been available, that they would have considered killing themselves or attempting self induced – a self-induced abortion.

Q Have you seen women who want an abortion for health reasons, physical health reasons?

A Yes, sir.

Q Where the reason – where the abortion would not necessarily save the woman's life but only to preserve her [p. 134] health?

A Yes, sir, I have.

Q Can you give me some examples of that?

A Renal failure, severe renal disease. I shouldn't say renal failure. Severe brittle diabetes where they were remaining hospitalized to keep their blood sugars in reasonable control, that they were too brittle to even maintain any kind of control outside of the hospital and hyperemesis gravidarum where they constantly vomit with the pregnancy and can't keep food down and lose a good portion of their body weight are the three that come mostly to mind.

Q Do you believe that those situations would fall outside the life – the exception for partial-birth abortions necessary to save the life of the mother?

A Yes, I do.

Q So those – such women would have to use, if they wanted to end the pregnancy, some method of abortion that was not a partial-birth abortion, is that right?

A Some method that wasn't covered by this law, and I don't know what partial-birth abortion is. I can't answer that.

Q That's why I was using the term. Some method that is not covered by this law. For such patients who suffer from some sort of health problem where they would like to obtain a D & E abortion or any abortion that you believe is covered by the law, what would the effect be on them of not being able [p. 135] to get the abortion? Take the example of a hyperemesis you described.

A I think you could – We see people as early as 7 and 8 weeks for hyperemesis. We see them routinely in the 12th to 15th week, but I think they would be told that they would need to either stay hospitalized. The woman that comes to mind most recently was 18 weeks that was brought here by – She was hospitalized on IV fluids up until the time they discharge her from the hospital in Benkelman, Nebraska, and drive 10 hours to Omaha, have her procedure, and then they took her back to the hospital where she was kept on IV's for 24 more hours after the procedure. It would mean that they would continue whatever disease process they had for an extended period of time until, I think, the abortion would be possible, or it would mean that they would have to travel further to another clinic in another jurisdiction where something could be done for them.

Q If a woman had to wait until the time at which you felt comfortable inducing fetal demise, would that also increase the cost of the procedure for her?

A Increase the cost. You can take that both ways. Increases the financial cost to her. It also increases the medical risk cost, the chances of her being – having some kind of an injury or complication goes up very – I think

Dr. Henshaw said something about 10% per week after the 12th [p. 136] week, or I'm not sure what his testimony was, but the numbers do drastically change. The studies that I'm familiar with is an abortion in the earliest stages is approximately 35 times safer than the childbirth as far as all complications across the board. By the 20th week, they are approximately equal to childbirth, and to make a woman increase her risks from one out of 35 times as dangerous as having a fetus in a normal pregnancy to a number that is 20 or 30 times greater than that doesn't seem to be in their best interest.

Q Are you concerned that if this law were, in fact, you might be prosecuted under it?

A Yes, sir.

Q Why are you concerned about that?

A I guess given my relationship with the attorney general, I've already been investigated for breaking a law which had been ruled unconstitutional 15 years ago, yet he still initiated proceedings against me under that law. It was eventually, I assumed, discharged because I have never heard any further reaction, any further comments on that, but, you know, several – several sessions with attorneys took place, and a lot of money was spent, and a lot of aggravation was undergone, I'm sure, by both sides to [sic] – I don't know what to call this.

Q Do you know if there has been any or has there been effort to, by the State, to investigate the methods of [p. 137] abortion you use?

A Yes, sir.

Q And in what context did that occur?

A I believe we had a formal meeting with the State Department of Medicine. I think the month was December of '96, possibly November of '96.

Q And what occurred at that meeting?

A It was a session where myself, and I believe you and Mr. Hug were present, along with several members from the State Department of Medicine investigative board, and they reviewed my practice in-depth. It also consisted of an investigation by the Department of Medicine investigator and a Federal Bureau of Narcotics board of investigation where they did an inventory of every patient's drug use that I have had in my clinic for the past three, actually four years.

Q Do you know what the result of that investigation was?

A No, sir. I have never been told.

Q When did the federal agent come to your –

A I believe that was in the early fall of '96. I'm not sure of the exact date. Possibly August or late summer, early fall of '96, and she was brought there by the state investigator.

MR. HELLER: I have no further questions, Your Honor.

THE COURT: Counsel, you may inquire.

[p. 138] CROSS-EXAMINATION

BY MR. SMITH:

Q Dr. Carhart, concerning your testimony that you thought if you were going to be prosecuted, you wouldn't

do abortions after seven to 18 weeks; do fetuses have sharp bones at eight weeks?

A I wouldn't believe so.

Q So as far as one of the complications concerned about intentionally having sharp pieces through the cervix if you had to cut the fetus up in the uterus because of the risk of sharp bones, that really isn't true at eight weeks, is it?

A I'm not aware of any way to cut the fetus up in the uterus during gestation.

Q But at least the risk of sharp bones from the fetus perforating the uterus at eight weeks, that is not a risk, is it?

A I don't believe I stated that it was.

Q If I misunderstood you, I apologize. Are you familiar with what is known as the American Board of Medical Specialties?

A Yes, sir.

Q And would you agree that that is an organization which is authorized, it has 24 medical specialty boards which certified physicians who are practicing specialties in the United States?

[p. 139] A I agree that that part is true.

Q Okay. And are you certified by any medical specialty board?

A No, I'm not.

Q One of the medical specialty boards would be the American Board of Obstetrics and Gynecology, is that correct?

A That's true.

Q Another would be the American Board of Surgery?

A Yes.

Q American Board of Family Practice?

A Yes.

Q American Board of Medical genetics?

A I'm not totally familiar that's the exact wording, but there is a medical genetics section.

Q And you're not certified by any of those boards, are you?

A That's correct.

Q Have you ever attempted to by come [sic] certified by any specialty board?

A I completed the residency in general surgery. I never attempted to take the boards.

Q How many years have you practiced medicine?

A Twenty-five, 24.

Q And do you have hospital privileges at any hospital?

A Not at this moment.

[p. 140] Q Would you need hospital privileges to admit a patient to a hospital?

A To admit them to your own service. You would not admit them to another person's.

Q Admit to your own service would be admitting them so that you would be the treating physician, correct?

A Can I just correct – I'm not sure about my status at Midlands right now. It's in – I don't know whether – I have been able to admit patients there, but I have been notified that my privileges were terminated. Well, it's under appeal, and it's under – The hearing is next week.

Q So as we speak, there is no hospital at which you can admit and treat patients, is that true?

A That's correct.

Q And in light of – You jumped ahead. One of my questions, have you had your hospital privileges revoked at any hospitals in the past?

A Yes.

Q And how many hospitals?

A Just one.

Q Is that the Midlands Hospital?

A Yes, it is.

Q Have you ever surrendered hospital privileges at the request of the hospital?

A No.

[p. 141] Q Now, as part of your medical background, you completed a medical residency, is that correct?

A That's correct.

Q Can you explain just what a medical residency is and then the type of medical residency that you completed?

A My medical residency was in general surgery. It's an intensive training program consisting of a number of years.

Q And I take it if you would complete a residency in surgery, the purpose would be – would have been to do surgeries in hospitals?

A That's correct.

Q How long has it been since you've done a surgery in a hospital?

A April of this year.

Q Would that be at the same hospital?

A Midlands.

Q You interrupted my question, the one in which your privileges are currently, I guess, suspended.

A That's correct.

Q As far as then your practice, your practice at the present time is in a clinic setting, is that correct?

A That's correct.

Q And in which clinic or clinics do you practice?

A I practice in Bellevue, Nebraska, at Bellevue Health Center and we practice under a clinic name also at that same [p. 142] address of Abortion and Contraception Clinic of Nebraska, and I practice at a clinic in Dayton, Ohio, under the name of Women's Med Plus, and I also practice at a clinic in Cincinnati, Ohio, with the same name. I also practice in a clinic in Akron, Ohio, with the same name.

Q Is there any reason for the two different clinic names in Bellevue?

A We started out with the intention of keeping the clinic separate. When the State passed their law regarding clinic licensure, we felt that there was little need to to duplicate two clinics at the same address and two licenses, and as one clinic was simply a trading name on the other clinic anyway, the name was there, we haven't changed our stationery, but effectively, we do everything under Bellevue Health Center.

Q And who owns the clinics in Bellevue?

A Bellevue Health and Emergency Clinic, Incorporated, is a corporation.

Q Who owns the stock?

A My children, my father's estate, and my brother, and I believe that's it.

Q Who's – Are you the controlling shareholder?

THE COURT: Counsel, pardon me. What purpose is this serving?

MR. SMITH: Well, I suppose I can move on to the purpose.

[p. 143] BY MR. SMITH:

Q Who actually controls what goes on in your clinic, Dr. Carhart?

A My wife is administrator.

Q Who actually determines the medical procedures there? What I'm getting at, is it you?

A No, there is no other physician present.

Q Okay. And it would be an accurate statement there is no type of peer review at your clinic like there would be at a hospital, is that correct?

A We have, as part of the National Boards and Federation, we submit all of our statistics to them. We submit all the complications to them, we submit all the reports of our patients' evaluations to them. I think we probably have a greater peer view than the average practice in the state of Nebraska including those in the hospital.

Q Do you think you have got better peer review at your clinic than would be in the hospitals? Is that what you're saying?

A I would be happy to say that.

Q Would you agree that a hospital, the medical procedures, at least, are subject to justification by the other physicians who have privileges there?

A Yes.

Q And that's not the situation at your clinic, is it, [p. 144] since you're the only one who practices there?

A What's the situation?

Q There is no other physician that practices at your clinic other than you who determines what you can and cannot do at the clinic, is that true?

A At my particular clinic, there is no one else, but at the national level, there are other people for us to maintain our certification with them, that we have to practice within their guidelines.

Q Okay. Now, as far as the fees that you've testified to, and you broke down the fee schedule, do you know what the fees would be that you've received from performing abortions in 1996?

MR. HELLER: Objection, Your Honor. I thought this was going somewhere. I wasn't sure where, but I have no idea what possible relevance could be of the doctor's –

THE COURT: Counsel, would you tell me about relevance?

MR. SMITH: Relevance would be motivation and bias, obviously, if you have a financial interest in what you're doing.

THE COURT: How far are we going to go with this?

MR. SMITH: At least – I think it's sufficient to at least to inquire the extent of the financial interest, Your

Honor. I think I should be entitled to at least make a [p. 145] presentation of how much.

THE COURT: The objection is overruled. Doctor, you can answer if you understand the question.

THE WITNESS: Nothing.

BY MR. SMITH:

Q Do you know how much you received in fees from abortions in 1996?

A How much I personally received from abortions in 1996 as paid from the corporation?

Q Yes. Well, let me ask you, are you paid by salary?

A No, I'm not.

Q Do you know how much the corporation has received in fees?

A Actually, no, I do not.

Q And as far as, is there a figure that you know that you've received in fees from performing abortions, either directly or through the corporation?

A Yes.

Q What is that?

A Zero.

Q And where do the fees go, then, if you did not receive them?

A Right now they have gone into the developing the corporation.

Q And what do you mean by developing the corporation?

[p. 146] A Attempting to purchase the building, doing the improvements to the building, paying staff, buying equipment.

Q You are paid a salary?

A I'm not – I have not taken a salary yet from the business. My salary is from the United States Air Force retirement, so –

Q So women come in for the abortions, you do not receive any of the fees other than –

A In 1996, I did not.

Q Other than just simply the corporation acquiring assets, is that true?

MR. HELLER: Objection. Him getting fees and the corporation obtaining assets are two different things since he's not an owner.

THE COURT: Sustained as to form.

BY MR. SMITH:

Q Does the salary that is paid go to your wife then?

A My wife receives a salary for working at the clinic.

Q And I assume that goes to the family household. You live together?

A I think that it does.

Q How much does she get paid?

MR. HELLER: Objection, Your Honor.

THE COURT: Sustained.

MR. SMITH: I would like to make at least an offer [p. 147] of proof.

THE COURT: Make your offer of proof.

MR. SMITH: The offer of proof requires him to answer the question.

THE COURT: No. Make your offer of proof if you know what the answer is.

MR. SMITH: I don't know the answer, Your Honor, so I can't show what the answer would be.

THE COURT: The objection is sustained.

BY MR. SMITH:

Q Would it be an accurate statement that the fee schedule you related earlier that the amount of fees are based, in part, on the complication for the procedure?

A Can you –

Q How do you – What is the reason why, as there are more weeks advanced in the pregnancy, the fee is higher?

A The amount of effort and time, the material costs, labor costs. We're talking an investment of my time of five minutes or 10 minutes in an eight-week pregnancy as opposed to maybe 45 minutes to an hour in a 20-week pregnancy.

Q Am I correct in understanding, then, as far as doing an abortion by an induction procedure, that you do not do that at the clinic?

A That's correct.

Q And the reason being what?

[p. 148] A The reason, I believe, that the induction is a less acceptable method of abortion. I think it has higher risks, I think it has greater cost to the patient in factors other than money, and I think that the greater amount of facilities, as Dr. Henshaw testified in his testimony, the hospital cost of three to four times what the outpatient environment cost is, I'm sure the outpatient cost to provide that service would be equally the same as the inpatient cost, so there is no justification, nor is there a need.

Q Are you aware that table 4 –

A I don't have that document.

Q Do you have Exhibit 7 in front of you, the AMA report? If you do, turn to page 10, please.

A Okay. I have that.

Q Do you see that the mortality rates for induced abortion procedure is 13 weeks or later. There it shows for more than 21 weeks. It's got a higher rate for dilation and evacuation than for labor induction?

A I think I would like to direct your attention to line 2 which states that this was created in 1987, and I don't think that at all relates to the abortion industry as it is today.

Q Do you know what the mortality rate is now?

A I don't believe that has been studied. At the last reported instance that I was just published in – was – I can't exactly quote on it, but it was a review by the State [p. 149] of Texas, I believe against Dr. Chris's most recent death, and I think they published an acceptable risk at the present time of 1.5 deaths per million.

Q You would agree that the AMA, when they issued their report this year, elected to use this table of statistics that appears on the sheet?

A It appears that's what they used.

Q The ultrasound, have you used the ultrasound for the early gestation stage termination procedures where you are terminating by medication? Did I understand you correctly that you used the ultrasound during the early stage medication termination?

A I used the ultrasound in making the determination that they are eligible for that, but we don't use it during – Well, we use it to check them as they progress through, yes.

Q And the purpose for using the ultrasound for the early stage gestation procedures is what?

A To determine if the patient fits the criteria for the use of the drug.

Q Which would be what?

A Less than seven weeks, six days of menstrual dating.

Q I have a note here. Is it accurate you use the ultrasound in some method to confirm, after the administration of the medication, that the fetus is not living?

[p. 150] A Yes, sir, that's true.

Q How do you determine that the fetus is not living with the ultrasound?

A It's different. It has a different picture.

Q I mean, since that's a very young, early-age fetus, are you comfortable that you're able to determine from the ultrasound whether the fetus is alive or not?

A Yes, I am.

Q And would you agree that as the gestational age advances, that it would become easier to determine whether or not the fetus is living with the ultrasound, or does it make any difference?

A I don't see – I think that determination can be made at any gestation.

Q And when you're determining at the early stage of gestation, when you're terminating it with the medication, that the fetus is not living, how do you determine the fetus is not living; in other words, what do you mean by not living?

A The gestational sac that was present on the preceding picture has been replaced by a homogenous clot mass.

Q And is there some other method of determining the fetus is not living that you go further on in gestational stages through the use of ultrasound?

A Sure.

[p. 151] Q What is that?

A I would think fetal movement and fetal cardiac movement.

Q You can determine those by the ultrasound?

A Yes, sir.

Q And the absence of those things tells you the fetus is no longer living?

A You can – Yes.

Q Would it be an accurate statement, before you commence an abortion procedure, you would always be able to determine through the ultrasound whether or not the fetus is living or not?

A I don't think so.

Q Can you explain that?

A I think you can tell what's happening in a normal fetus because there has been a lot of data that when nothing is intervened with it, and you see a heartbeat, and you see fetal movement, that you can make the assumption that it's a living fetus. I think when you can see that the fetal tissue where there is actually no heartbeat and no fetal movement, that there has been fetal demise, but I think there is a gray area where you can often see or not see things and not be 100% sure of what is happening at that point, and I don't know how large that gray area is.

Q You understood me to ask you before you would start an abortion procedure?

[p. 152] A No. I guess you better rephrase that question.

Q My question was, before you start the abortion procedure by that process, but you would extract, remove the fetus in some manner, are you always able to tell before you start that process whether or not the fetus is alive or not?

A No.

Q Could you if you wanted to?

A I could tell you when it is dead. I can tell you when it's definitely alive. I can't tell you, I can't tell you during the interim point where it may – where the living, some of the functions have stopped and some of the other functions have not stopped.

Q Do you consider the absence of a fetal heartbeat meaning the fetus is dead?

A No.

Q Do you know if general medical standards would consider the absence of fetal heartbeat to be fetal death?

A I don't know any medical standards that determine what fetal death is. I'm not aware of a publication or anyone that has done a study to say – Again, I'm confused by what you're getting at. Are you asking me, is the fetus going to be able to live afterwards? Or are you saying, are all the tissue, all the structures, all the cells in that fetus dead? I can tell you it does not have a heartbeat. I could be very specific with that. I could tell you that to the second it [p. 153] stopped as to what the rate is, but I can't tell you that the cells in the arms and the cells in the fingers and the cells in the brain and even the cells in the heart have died.

Q But you can tell from the ultrasound whether or not there is or is not a fetal heartbeat?

A Yes, sir.

Q Can you also tell that through a fetal heart monitor?

A I have not worked with a fetal heart monitor since 1960, and at that time, they were inaccurate even with the adult fetuses we were trying them on.

Q Would it be an accurate statement you're not familiar with fetal heart monitors at the present time?

A I don't know of any of them that would – that you could use on this type of a fetus, yes.

Q Other than ultrasound, is there any other method of determining whether or not there is a fetal heartbeat?

A If you are getting the Doppler, that is a form of ultrasound, so I think that's the same question.

Q And I'm sorry. I didn't hear what you said after the Doppler.

A The ultrasound Doppler is the audible – the ultrasound that they put on a woman's stomach to listen to the heartbeat is an adoption of the same thing we're looking at on the picture. It's just converted into an audible tone as opposed to a visual tone.

[p. 154] Q Are you talking about just digital equipment that would attach to the ultrasound?

A It's a separate piece of ultrasound equipment.

Q And do you have that equipment?

A No.

Q Now, the ultrasound, would you agree that that is a device that a person can videotape?

A It could be.

Q So you can have a record for posterity that shows what the results were of an ultrasound when it was performed?

A Yes, sir.

Q Now, the procedure that you described, the third procedure you described for doing an abortion had vacuum aspiration. Do you know, is that accurate? You do a vacuum aspiration?

A Suction D & C, vacuum, whatever.

Q That would be at the later stage after it's too late in the pregnancy to do the termination by the medication method, correct?

A No. It could be as early as three weeks.

Q Oh, okay.

Q But the vacuum aspiration, would it be an accurate statement that what you do as part of the process, you insert a tube in the uterus?

A Yes.

[p. 155] Q And the purpose of the tube is what?

A To remove the uterine contents.

Q And can you just tell us the dynamics, how that actually happens? I'm just – It's a vacuum? Is it pulling of air, or how does that actually work?

A I think the correct statement, is nature abhors a vacuum, so it's the pressure of the uterus pushing the contents through the tube to the lower pressure area.

Q Is it a power-driven device?

A Yes, it is.

Q What type of power? Electric?

A They come both battery-operated, they come hand-operated, and they come electrically-operated.

Q And when you use that method, the fetus goes from the uterus directly into the tube, correct?

A Sometimes.

Q Where else would it go?

A Very often, the tube becomes clogged, and you have to take it out, and as you take it out, the uterus will expel the contents into the vaginal cavity.

Q Is that something you intend, or is that a spontaneous event when that latter circumstance happens?

A My intent is to get it out.

Q Your intent, I would take it your intent is to, through the vacuum, remove the fetus while the tube is in the uterus?

[p. 156] A My intent in every abortion that I have ever done is to kill the fetus and terminate the pregnancy. I think that's the specific intent that I enter the room when I go to talk to the patient. That's what she's asking to do, and that's what I'm there to do, and I do what I have to do to get that done.

Q But when you're doing the vacuum method, is it your intent to remove the fetus from the uterus by delivering it partially into the vagina?

A No, I wouldn't say that. Could I ask you for clarification on that? Because it goes through the tube through the vagina. So I have to say that, yes, it's my specific intent to remove it through the vagina within the tube, but it does not always happen that way, and I enter into the procedure knowing that it's not always going to happen that way.

Q I think that was clear, or hopefully, it should be clear to the Court. At least I understand it. Now, do I understand that when you do abortions that you never attempt a procedure where you try to turn the fetus so it's in the breech position?

A I think my statement was that I don't go to the lengths that was the – There was a large amount of discussion about going in and mechanically trying to turn the fetus. I don't – I don't intentionally spend a lot of time doing that. If [p. 157] it is a transverse lie, you can't bring the fetus out sideways, so you have to bring some presenting part through, and you have to turn the fetus in order to do that. It may not be a whole 180 rotation. It may be a 90 degree rotation or a 45 or a 60, but you have to mechanically orient some portion of the fetus to come through the cervical canal.

Q But as far as deliberately trying to get the feet so that they are coming out first, do you do that?

A If it's easy to do, yes. If it's not, then I don't spend a lot of time doing it.

Q Just depends on the position the fetus is in when you start the procedure?

A Absolutely.

Q So if it's in a position the head is coming out first, you don't rotate the fetus around to get the feet, correct?

A No, sir.

Q If it's already the foot coming out first, then you take what you can get?

A That's what it is.

Q Now, as I understand your testimony, that beyond 15 weeks, you do intend to remove the fetus as intact as possible?

A I think that would be a fair way of stating it.

Q And your reasons why you want to remove the fetus intact, if possible, after the 15 weeks would be what?

[p. 158] A To minimize the maternal complications.

Q And those would be what?

A Possibilities of laceration of the cervix, perforation of the uterus, absorption of fetal cellular debris into the maternal circulation through placental, the uterine placental interface.

Q Now, what are the mechanisms that would lacerate or perforate the uterus?

A The mechanism would be a sharp-pointed object in opposition to the wall of the uterus.

Q Okay. Would a forcep create such a risk?

A It certainly could.

Q And the complication, if I understand it, and you correct me if I'm wrong, is absorption of fetal material into maternal –

A Maternal circulation.

Q By that, you mean the bloodstream?

A Yes, sir, the maternal bloodstream.

Q How does that absorption occur?

A Through the – As the placenta separates from the uterine wall, there are no blood vessels between the uterus and the placenta. There are only blood sinuses, actual cavities in the uterus. The bleeding stops because the uterus contracts and these cavities are allowed to close, and until you've emptied the uterus, the cavities remain open, so [p. 159] there is essentially a sump pump effect involved in maternal – into the maternal circulation of whatever is in the uterine cavity. It just can flow in, and the cellular structures from the brain and the cellular structures from the skin and the fetal blood are the three biggest concerning factors, and that's why we do Rh testing and why we gave Rogam to all of our patients that are Rh negataive [sic] because we know there is a mixing of fetal blood and fetal debris into the maternal circulation in every procedure.

Q Do you know what the complication rate is then?

A The frequency?

Q Yes.

A I believe the present numbers we tell the patients are less than one in a thousand.

Q And as far as your basis for that, is there some statistical support for that?

A Yes. That's numbers that come out of the CDC on approximately an every two- to three-year basis.

Q That would be the Center for Disease Control?

A Yes.

Q Now, if one was compressing the skull from the outside, do you understand what I mean from the outside, the fetus's skull?

A Okay. I think so.

Q You could do that with a forceps, for example?

[p. 160] A Yes.

Q Is it your testimony that if one compressed the skull sufficiently, one of the risks you run is having the contents of the brain or the skull be released into the mother's bloodstream?

A I'm stating that it's released into the uterine cavity. It's either going to go into the uterine cavity, or if it ruptures on the side nearest the cervix, it's going to come out of the cervix. It has been my particular experience that this happens probably equally, that it can go either way, and often goes both ways.

Q By both ways, you mean going down?

A Internal, up into the uterine cavity and out the uterus, out the os. I think that would be testi – It would

be my testimony that once this material is floating in the uterine contents, that it has the possibility of being absorbed through the sinuses.

Q Now, as far as that risk, the skull contents being released into the uterine and then getting into the mother's blood supply, is that risk at all stages of gestation or only at a certain point?

A I think probably only after the point – Well, after you've started to crush the skull where that would become a factor, or where you start to macerate the tissue of the fetus which is the 14th, 15th, 16th week and on.

[p. 161] Q Does it make any difference whether the fetus is alive or dead?

MR. HELLER: Objection. Make any difference to what?

BY MR. SMITH:

Q Does it make any difference as far as the fetal material being – the risk of that getting into the mother's blood supply? Does it make any difference whether the fetus is dead or alive?

A As far as the skin tissue, Dr. Hansen has done some studies where it is implied that this is true, the longer the fetus has been dead within the uterine cavity, the greater the chance of fetal cells sloughing, and not even with mechanical movement. Her studies were, when you had natural field demise from other than abortion standpoint, and a period of time that lasts between the field demise and the induction of labor, or the completion of the abortion, the longer you waited, the higher number

of fetal – the greater the amount of fetal elements that could be detected within the maternal blood supply.

Q Now, you described earlier in your testimony, as I understand it, a process where there would be occasions when you're trying to remove the fetus intact that you would remove to the point of the head, correct?

A Um-hm.

[p. 162] Q The answer is yes?

A Yes, sir.

Q And the reason you don't get the head out would be, there would be occasions when the cervix is not dilated far enough to allow you to remove the head, correct?

A Correct.

Q And those would be occasions in which you would attempt to reduce the size of the head in some manner, correct. Tell us the manner by which you would reduce the size of the head.

A I think the only two mechanisms possible are to use forceps to compress the skull, and rupture the skull, and allow the contents to flow out of the brain or –

Q And let me stop you there. If you did that, that runs the risk of perforation from using the forceps?

A Well, you have to use something.

Q But you would agree it does run a risk of perforating the uterus by using the forceps, true?

A There has to be a small risk of that, yes.

Q And then the other risk would be, as you said, the contents of the brain being released into the uterus and the mother's blood system, correct?

A Yes.

Q Now, the other method that you could reduce the size of the head other than forceps would be what?

A If, and you know, I mean, things don't always happen the [p. 163] way we would like to see them happen. Very frequently, we'll get down to the skull, and the skull will separate from the body cavity, I mean, from the neck. It will break off, so you have the fetus out and the head intact inside, and you're again going back and grasping the head and breaking it down, so that's a second method, I guess, and thirdly, if we can get enough of a portion of the skull outside of the cervix, we can make some kind of an opening into really any portion of the skull that has the cranial contents in it, use either vacuum aspiration, or many times we just allow the contraction of the maternal, of the uterus, the compression of the cervix and the uterus on the skull itself to empty the contents out into the vagina, and then we pull the skull on through.

Q It just comes out, correct?

A It just comes on out.

Q The obstruction really presented by the size of the head is the cervix. Once you get past the cervix –

A Once you're passed the internal os of the cervix, then you're out.

Q Now, once you've removed the fetus, you then do something to clean out the insides of the uterus?

A Once we have removed the fetus, we then have to remove the placenta normally. Sometimes, unfortunately, the placenta will come out first. That's usually, uterine [p. 164] massage, we try to do that on external massage on the abdomen of the woman causing it to separate and spontaneously pass. If that doesn't happen, then we'll go back with forceps and attempt to remove it, start it to come out, and then usually, it will come out on its own.

Q What is the curettage?

Q Curettage?

A Yeah. What is that part of the abortion? What is the purpose for that?

A Two purposes. One is to remove any remaining placental fragments off the wall of the uterus. The other reason that I do curettage on every patient is, there is a small frequency of partial moler pregnancies where you have a normal living fetus as well as a moler pregnancy tissue which is a cancerous growth. The treatment for moler pregnancy is sharp curettage of the uterine cavity. I do that. I think the incidents that's reported statistically for that happening is one in 30,000 pregnancies where you have the combined, and we have we have seen three that we have diagnosed that have had partials moles, and all three of their follow up care have been that they were already taken care of, that the curettage done at the time of the procedure was a treatment for the moler pregnancy, so I feel that that's the other reason why I do curettage on all of the women.

[p. 165] Q Is one of the purposes for the curettage to remove any of the remaining fetal debris?

A Sure, as well as placental debris.

Q Is that because the fetal debris and the placenta, placental debris, if left in, creates the risk of getting into the mother's bloodstream or infection?

A That and infection and greater bleeding. It probably will all come out and wouldn't be of any sequelae, but I think you can reduce the complications for the woman by a better clean-out procedure.

Q What is the approximate time frame that passes from the time you remove the fetus until you do the process in which you're cleaning out the inside of the uterus? Does that just – it follows immediately after?

A Minutes.

Q Okay. How long does it take to do that process of cleaning out the inside of the uterus?

A The entire –

Q By that, I mean, after the fetus is out.

A After the fetus is out, usually two to five minutes. Depends on how much difficulty you have with the placenta.

Q And if the physician does a good job, in other words, removes the remaining debris from the uterus within that five-minute period, is there, really, should there be any risk to the mother of infection or debris getting into the [p. 166] bloodstream; in other words, if you do it right, the risk should be gone?

A I think there is always the potential for bacteria to be left behind. We can't get down on that level, so the risk of infection, I can't say, is gone. I think you try to minimize it. I think that would be fair. I'm not sure you can say that it's ever gone.

Q Do you have any statistics or know any statistics on what the risk is – That essentially is getting into the skill of practitioner, so I will withdraw the question.

THE COURT: Counsel, give me a sense of how much longer you'll be.

MR. SMITH: If I could do a quick scan of my notes, I could answer.

THE COURT: Sure. I just figure I'm going to take our break, counsel.

MR. SMITH: I would guess it's going to be at least 15 minutes, could be longer. You might want to take the break.

THE COURT: Would this interfere with your cross if we break now?

MR. SMITH: No, not at all.

THE COURT: Why don't we take our mid afternoon break at this time. It's now about 2:51. We'll be in recess for 15 minutes. Doctor, you may step down.

[p. 167] (Recess from 2:51 to 3:11 p.m.; all parties present)

THE COURT: Counsel, you may proceed.

BY MR. SMITH:

Q Dr. Carhart, I wanted to ask you about your testimony where you described inducing, I have it here, fetal demise by the injection of Digoxin, is that correct?

A Digoxin or Digoxin, that's correct.

Q And that's the actual medication that would kill the fetus?

A Lanoxin and Digoxin, yes. Medication from the Digitalis group that's used in adults to control rapid heart rate.

Q And your testimony is, you do that on all patients after 20 weeks?

A All that would not have a contraindication to using the medication or that would wish not to have it done.

Q Is that after 20 weeks gestation or beginning of 20 weeks gestation?

A Yes.

Q Well, no. I mean, are you saying it's actually – it's –

A During the 20th week, I don't think, you know, I don't think I have any black and white in my practice. There is a lot of gray areas.

Q And the method you use, you do the injection, you wait 40 to 72 hours later and perform the abortion?

[p. 168] A I think I – I think I said from – I'm not sure what I said, but in reality, it would be on day one,

we would do the injection, that could be as late as, say, 2:00 or 3:00 in the afternoon. Day two, we would change lams, and day three, maybe as early as 8:00 or 9:00 in the morning or 3:00 or 4:00 or 5:00 in the afternoon, depending on how the patient had progressed, we would do the procedure.

Q And the reason why you don't do the injection prior to 20 weeks is what?

A I haven't found – First of all, I don't think there is any published data to research, so I'm stuck with my own series, I guess one has to call it, of anecdotal-type information and also in discussing with my friends, and I have not seen where the benefits of using the medication are greater than the risks in the earlier terminations.

Q If I understood correctly, when you do the injection after 20 weeks versus not [sic] your prior experiences, you didn't wait as long during your prior experiences with the injections before you would remove the fetus, is that correct?

MR. HELLER: Objection, only because I'm not sure I understand the question.

BY MR. SMITH:

Q Okay. Well, as I understood it, you testified that you used to do the injection after 16 weeks.

[p. 169] A Correct.

Q You stopped doing that, and you now do it generally after 20 weeks, correct?

A I used it 16 through whatever dating I did I stopped doing it with the 16th, 17th, 18th, 19th, and

usually the 19th, sometimes even with 19 weeks, if the patient requests it, I will do it. At 20 weeks, I would leave it pretty much up to them whether they want it or not. By 21 weeks, I really would like them to do it.

Q But during, when you used to do it between the 16 and the 20 weeks, would it be accurate that you didn't wait as long from the time you did the injection before you started removing the fetus?

A After the 20th week, the procedure goes into a third day. I wouldn't want to make a patient wait an additional day. I think, if I remember my testimony, what I said was that with only the 16- or the 12- to 24-hour time hiatus that we would have after doing the injection, I didn't see enough of a change in the size of the fetus that it was really an advantage, and I didn't see enough softening in the - softening of the fetal structures to have an advantage from it, so that I was left with possibly a little less bleeding and possibly some other benefits but also some significant, I thought, risks that would counterweigh that.

Q What's the reason for the additional third day after 20 [p. 170] weeks?

A To get additional dilatation of the cervix. You normally would remove the laminary that you have put in the first day and add more because you need considerably more dilation by the 20th week than you do by the 18th or 19th week, and also, if you have a fetus that's alive, you know, you may start at 20 weeks and two days, but you have gone another two days, and you have got a fetus that's doubling in size every two – every eight or 10

days, so the growth of a 20-week, two-day fetus is significantly smaller than a 20-week, four-day fetus, and if you terminate the pregnancy at 20 weeks, two days, then it actually starts to get smaller, so with that extra day, you know, you may be doing a pregnancy that's at least a week less in gestation by the time you are ready to do the procedure.

Q As far as when Digoxin is contraindicated, in other words, you wouldn't use it at all, is that what you mean by contraindicated?

A Whether medical problems in the patients that would preclude or make it ill advised to do that.

Q And your three reasons would be seizure disorder, heart disease and –

A Well, seizures, Lidocaine can induce seizures in people. If they have already have [sic] a seizure disorder, triggering further seizures, not that they wouldn't be treated, but it [p. 171] would be an additional risk.

Q Second reason was heart disease?

A If heart disease was being treated by Digoxin already where they might already have an maximum dose on board where any additional absorption in the maternal circulation would be a problem.

Q Is there any other medication that could be injected, then, to cause fetal demise?

A I'm sure there is, but I don't know if anyone is doing that. In very very early pregnancies, there has been some work with potassium chloride, but that's in very minute amounts. The amount needed to terminate a fetus

that size would possibly be close enough to cause severe maternal complications or even maternal death if any was gotten into the maternal circulation. I don't know of any other studies of drugs.

Q Well, when you do the injection, I assume you're using ultrasound?

A Yes, sir.

Q That's guiding you so you're injecting into the right place?

A It's giving me two dimensions of a three-dimensional world.

Q That's, frankly, it's being able to properly inject is a matter of physician skill?

[p. 172] A I believe so, yes.

Q Skills are acquired. I mean, you learn how to –

A One would hope.

Q As far as just the mother's right to choose an abortion, I take it there is some method of informed consent that you go through at the clinic?

A Yes, sir.

Q Is there a form involved, form or forms that they sign?

A We have a form, actually have multiple forms and forms that both the patient signs, forms that both myself and other people who talk to them sign, to assure that on more than just one occasion, they have asked that they consider all their alternatives, and that takes place both at

the initial counseling which is required by the State of 24 hours in advance of termination as well as, again, on the day of termination.

Q Does the form actually cover the procedure that would be used?

A If we're doing – We have a separate form if we're doing fetal termination, we have a specific form which states exactly what we are going to do, injecting the medication into the fetus or into the amniotic fluid or the placenta, and that's one consent that's signed. There is another consent for patients that are above, in the second trimester, and we have another consent for the use of the laminaria [p. 173] where we do a separate counseling, explain it to them, what the dilating, osmotic dilators are intended to do, what the complications can be, what the alternatives are, how they can avoid using them.

Q And as far as giving the mother the option on the medical procedure to be used, is that part of being informed?

A I can't state honestly whether it is or not. It's something that I discuss with every patient that's there. I'm assuming that if you say that they don't want to have an intact D & E or they do, I'm not – Maybe I don't understand your question fully.

Q You've testified so far to various medical procedures you use to perform the abortions?

A Right.

Q I'm just curious uf [sic] the form itself gives the option.

A We have different consents for each form, and I don't think we have any form that says we have 18 forms, kinds of abortions, which ones do you want and have them sign that, but depending on what they have indicated that they want, we will discuss, for instance, the medical – Everybody that signs the medical consent also has to sign a surgical consent so that we are a hundred percent certain that they understand what both procedures are and that they have chosen the medical knowing, that a given percentage, three-tenths of 1% of our current study will have to have both.

[p. 174] Q And what you've described as far as the forms, those are standard form documents that you keep at the clinic?

A Yes, sir.

Q As far as determining viability, do you yourself determine viability if the fetus is over 20 weeks? I wasn't clear when you talked about having a referral or having another physician.

A If they are coming to me where viability is a concern of mine, and I don't think 20 weeks, 20 weeks menstrual dating, that there is a remote concern, but if they are coming to me at a time when there is any concern of fetal viability, I will not use my judgment that the fetus is viable or not viable to continue with the procedure. I need the patient to come with a specific referral from her physician stating that X, Y, and Z are fetal flaws, and the fetus is not viable, and the patient needs to have this procedure.

Q And the next question is, when is viability of concern to you?

A Viability becomes a concern to me, I think, in approximately about the 22nd week. I think that, again, 22 week fetuses are not all the same. There are things that – maternal habits that can make the given possibilities of survival of the fetus at 22-week patient much less than the same identical gestational fetus in another patient.

Q I'm just trying to understand the protocol, the [p. 175] standards that you apply in making that determination. I have heard you say 22 weeks, but I'm not clear what the other factors are that you use.

A I think maternal use of drugs, maternal use of alcohol, where they are both known to cause smaller fetuses, cause increased mortality in fetuses, lack of prenatal care, fetuses that appear different than they should.

Q How do you determine –

A I think it's subjective.

Q And how do you determine the weeks of gestation?

A Generally by different measurements, calculations, by ultrasound, and comparing that with the dates that she gives us.

Q Dr. Carhart, when you had the federal investigator and state investigator contact you concerning your drug audit, was there an issue, as you understood it, as to whether or not you had a proper permit or controlled substance registration to have drugs at the location where you have them?

A I don't think they ever discussed the nature of the audit.

Q And do you have any understanding that there was some issue as to whether or not you had an active permit that allowed you to have drugs at a specific location?

A Was there an issue in my mind? Never.

[p. 176] Q Was there an issue in their mind from your perspective?

A I had my letter from the Department of Health which stated what was going on, and there seemed to be a good audit trail. I don't know why people don't talk to each other maybe, but –

Q Well, in any event, they were allowed to check your audit records for the drugs you had, and nothing has come of it since then, is that correct?

A I think the law requires I have to make that available to them.

Q But nothing has come of it since then, is that correct?

A That I'm aware of.

MR. SMITH: Nothing further.

THE COURT: Counsel?

MS. WALZ: Thank you.

CROSS-EXAMINATION

BY MS. WALZ:

Q I have just a few questions, Dr. Carhart. I think you stated previously that your clinic is located in Bellevue, is that correct?

A That's correct.

Q That's in Sarpy County, Nebraska?

A That is correct.

Q Since LB 23 became law, have you been contacted by the Sarpy County Sheriff's Department at all regarding [p. 177] investigation for partial-birth abortions?

MR. HELLER: Objection, Your Honor. I think there has been a temporary restraining order in effect.

MS. WALZ: That's correct, but there wasn't – I'm sorry.

THE COURT: Overruled. You may answer, Doctor.

THE WITNESS: I'm not aware of any contact.

BY MS. WALZ:

Q Any investigators ever call you? I mean, there was no contact at all from an investigator or any other deputy to your knowledge?

A Not with me personally. I'm not aware of it with any member of my staff.

Q Okay. What about anyone from the county attorney's office in Sarpy County, besides contact with me, between me and your counsel regarding this case.

A Well, I didn't know if that contact – We did have – The only thing that came to me was a direct communication from the district attorney's office in Sarpy – or no – the county attorney's, the deputy county attorney in his office, I had been subpoenaed as a witness for a trespassing violation by our protesters.

Q But that is not related to this case, is it, or to LB 23?

A Well, yes, it is, because they stated they called back [p. 178] and said due to the fact that we had filed suit against the county attorney in Sarpy County, that he had to –

Q A conflict of interest?

A Had to have a conflict of interest and had to appoint a special investigator.

Q But in terms of criminal prosecution instituted by our office, has that ever occurred since LB 23 was enacted?

A The only time that the bill was in effect, I was out of the state for the four days between the data the Governor signed it and the date the injunction was issued, so I don't know where –

Q I think it was eight days. I'm sorry.

A No.

Q I think it was eight days, but in any case, you never did receive a clinical complaint?

A I didn't do any patients in that interim that would come under – It was never –

MS. WALZ: Okay. That was my question. Thank you. Nothing further.

THE COURT: Counsel?

REDIRECT EXAMINATION

BY MR. HELLER:

Q Thank you, Your Honor. You were asked some questions about the risk – of, I think the risk of perforation from using forceps when you - if you were to crush the skull in an [p. 179] intact procedure, and then also about the risk of using forceps if you had to remove fetal parts that made it – smaller fetal parts that may remain. Do you recall that, those questions that were asked?

A Vaguely, yes.

Q Is the risk, in your opinion, is the risk of perforation that may occur in an intact D & E or D & X procedure greater or lesser than the risk in a D & E involving dismemberment?

A If I can go back for a second, I made – I believe I made a misstatement. I think I used the term Beier forcep and I was intending to say Sopher forcep, so if we can correct that. S-o-p-h-e-r, so if we can correct that part of it, then go on. I'm not aware of any studies that anybody that's done that said if you enter the uterus eight times with an instrument, that you have X amount of chances of perforating the uterus more than if you enter it seven times, but I think that every time – I accept the fact that every time I put anything in through the cervical os into the uterus, I'm running a chance of damaging the uterus, so the more number – the greater number of times that I

have to do that in a given procedure, I think that there is a multiplication factor of a complication rate.

Q And, then, am I right in understanding that the intact D & E procedure or the D & X procedure involves fewer insertions of forceps or other foreign objects into the [p. 180] uterus than a D & E involving dismemberment?

A Yes.

Q I wanted to call your attention to the – I guess it's Exhibit 7. Do you still have that one there?

A Yes, sir.

Q You were asked a question about the table at the top of page 10. Have you found that table?

A Yes, sir.

Q Now, that table indicates that from 1974 to 1987, the mortality rate for dilation and evacuation after 21 weeks is 11.9 per 100,000, and the mortality rate for labor induction after 21 weeks is 10.3 per 100,000, is that correct?

A That's what it states.

Q Now, if you look at the prior page, at the bottom of page nine, the last sentence, says, "Maternal mortality rates overall are higher for labor induction than D & E." Then there is a parenthetical, "But mortality rates resulting from labor induction D & E are comparable for induced abortions performed at 21 weeks or more." Then in parenthesis 11.9. Doesn't that seem to indicate that the AME believes that even after 21 weeks, that before – I'm

sorry. Before 21 weeks, mortality rates are higher for labor induction, and after 21 weeks, the rates of mortality are comparable for the two types of procedures as of – based on this table?

[p. 181] A I would have to – I think that one could draw that conclusion from this, but I have to preface that. I'm not familiar with the methods here and I don't know how much they would – we removed other complication factors. I know for induction, at least many people use anesthesia as part of the induction process, that they'll give either general or high doses of anesthetic agents during the later stages of induction, and I do know factually that CDC has stated that from 1970 through the present day, the maternal death rate from the complicating effect of anesthesia remains one-third of the total deaths that happen with abortion. That number has not changed, so if you add anesthetic component to an induction component, the compound number of deaths may certainly be higher. I don't know whether they extracted that out or not. I'm not that familiar with the study, but I think you have to take all the factors into consideration, and most of us do not use general anesthetic for dilatation and evacuation.

Q If you could just briefly turn your attention to page 11 of the same exhibit, and there is the last paragraph on that page begins, "In summary." Do you see that paragraph?

A Yes.

Q Does this appear to express the opinion of this – someone at the AMA that maternal mortality during

second trimester abortions is lower per dilation and evacuation [p. 182] procedures than for labor induction methods? Does that appear to be the opinion?

A That would appear to be what they are saying.

Q And that for procedures performed at 20 weeks gestation and beyond, the rates are similar?

A I believe that's what they are saying, yes.

Q You were asked some questions right at the beginning of your cross-examination about whether you had hospital privileges, and you mentioned a hospital called Midlands?

A Midlands Community Hospital. It's in Papillion, Nebraska.

Q Have you had hospital privileges there in the past for some period of time?

A I have had hospital privileges there since 1985.

Q Do you know what the basis is for the suspension and question about your privileges there, or is that yet to be determined?

A Well, the basis that I'm told of, as of yesterday's conversation with my attorney, was that they did not receive one letter of recommendation from one of my – one of my people, medical practitioners that I was asked to have provided, and they refused – He was told and that we received a letter that was addressed to him, but I received a copy of it stating that that was the only factor that was involved.

[p. 183] Q Do you know is there a hearing set?

A I believe it's set for June or – or July 26th or July 28th. I'm not sure.

Q Comparing, again, intact D & E with the dismemberment D & E or nonintact D & E, by removing the fetus intact, is there any difference in the risk of retained fetal parts?

A I think it's easier when you've got – I don't know a pretty way to put this – when you do a dismemberment D & E, you have a tray full of pieces, and it's impossible to take a total inventory to know that you've taken out all the tissue. When you do an intact D & E, you have either a fetus and attached placenta or a fetus and a placenta that has been divided at the cord, but either way, you have two parts, and you can see both of them, and they are intact. It's much the same as we look at a placenta in a normal delivery to make sure that it's all there. When you have one placenta and you can see a fragment missing, you can go back and look for it. When you have fragmented pieces of placenta, and the reason why the placenta is fragmented is as you are grasping part of the fetus, each time you grasp something, you can grasp a piece of the placenta as well and keep tearing off small fragments of placenta while you're doing the procedure. It's impossible to know that you have as good an emptying of the uterine cavity.

MR. HELLER: I have no other questions.

[p. 184] THE COURT: Doctor, before you step down, I have a couple of questions, and I want to concentrate now on the period of time between the 14th week and, let's say, the 20th week. During that period of time,

it is your preference to use what you call an intact D & E, is that right, the 14th week and the 20th week?

THE WITNESS: Yes, sir.

THE COURT: It's your preference?

THE WITNESS: It's my preference to try to do that.

THE COURT: Now, do you have a number for me, a sense of how many intact D & E's between the 14th and the 20th week, either as a percentage or a raw number so I'll have a sense of what we are talking about in your practice?

THE WITNESS: Are you talking about the total number of D & E's at that gestational period between 14 and 20, how many that would be?

THE COURT: Yeah, I suppose that would be the best.

THE WITNESS: I would say somewhere between five and 10% of the total number that I attempt. These are usually the 19th- and 18th- and early 20-week fetuses that come out intact, and that's a much lower percentage in, you know, quantitatively, the numbers are greater the 14-, 15-, 16-, 17-week period.

THE COURT: Than they are –

THE WITNESS: Than they are at 18, 19 and 20 weeks.

[p. 185] THE COURT: And that's because of the size of the fetus?

THE WITNESS: No I'm sorry. That's because of the patients coming in in earlier gestations. Our numbers that we start with are much greater in the lower range. We see, you know, the normal patient, the normal distribution of first trimester versus second trimester versus third or late after 24-week percentages in the United States is approximately 10% or greater than 14 weeks, and 1% of the total number are greater than 20 weeks. We see a slightly higher number than that because we do a referral base practice from North and South Dakota, Eastern Minnesota and Eastern Iowa and also parts of Kansas.

THE COURT: So between the 14th and the 20th week of the 800 or so abortions that you do a year, probably 10% of them?

THE WITNESS: Two hundred. No, probably 20% of my patients because of the skewed number probably, and this is the first year with our new reporting for the State and also with the National Abortion Federation that I will be able to tell exactly what the numbers are because we have to report that each week – I mean each quarter, but in 1996, to the best of my recollection, approximately 200 of the 800 were after the 14th week.

THE COURT: And before the 20th week?

[p. 186] THE WITNESS: Well, no, that would include those that were past the 20th week also, but that was a very small number.

THE COURT: Okay. Now, and all of those, you intend, when you begin the procedure, if you can, to do an intact D & E?

THE WITNESS: Yes, sir, I do.

THE COURT: Some of those you can purposely cause fetal demise in utero by use of an injection, is that right?

THE WITNESS: Yes, sir.

THE COURT: Tell me again, mechanically, what is the injection? What do you do, where do you inject, what medical risks are associated with the injection?

THE WITNESS: The injection process that we use is very much like the amniocentesis process used by all gynecologists or obstetricians during the determining complications during pregnancy. We use – we try to stay in the mid line where ultrasound, they are often forced to go off the mid line to avoid the fetus, and our intent, we would like to move the fetus to the mid line and go through the mid line of the abdomen because that's where least number of blood vessels are and where you are least likely to have colon or small bowel contents. We use an ultrasound in two dimensional plane to determine if the lie of the fetus, where it is, where the chest of the fetus is, and ideally, where [p. 187] the thoracic cavity and the heart is, because the closer that we can get to the thoracic cavity, the more likely the medication is to be effective early. We have injected totally into the amniotic fluid and usually see fetal death, but not for approximately 24 hours, but if you get intrafetal injection, then it's usually within 15 to 20 minutes.

THE COURT: And that's what you hope to do is to enter the thoracic cavity of the fetus as opposed to being satisfied with simply injecting into the sac?

THE WITNESS: Yes, sir.

THE COURT: Okay. Now, you don't do that procedure after the 14th week and/or from the 14th week to the 19th week, am I right?

THE WITNESS: Currently, I prefer not to. I have had some patients request it, and if they were rather thin women and 17, 18, 19 weeks, and if they – they really felt they were needed, I will do that. If there is a medical reason not to do it, then I would not do it.

THE COURT: And did I understand you to say that one of the concerns was that, for example, by using that injection, you run the risk of bowel perforation, and the offsetting benefits from doing it, such as emotional concerns of the pregnant mother, simply don't outweigh the risk of doing the procedure?

THE WITNESS: I believe that's correct. I think [p. 188] the chances of doing damage in the very early pregnancies, especially the 14, 15, 16 and 17 week because the uterus is usually down lower in the pelvis. You have to try to compress, manually compress the bowel out of the way, it becomes much, much more – It's more difficult for me to do it in the first place. You've got a much smaller target in the second place, so you are less likely to get a fetal injection than you are an amniotic injection, and I think the uterus is much smaller in its size, so you are more likely to perforate and go through the back wall of the uterus or into the back wall of the uterus and get a maternal injection.

THE COURT: All right. Now, for those situations, then, that you don't use the injection and cause fetal demise before you begin the surgical procedure, presumably – Well, am I right to presume that in the great

majority of those cases, the fetus is still alive when you begin the procedure?

A Even if I divide the cord, which I always attempt to do, when I begin the procedure, there is still –

THE COURT: I'm talking about as you begin to gown up and before you do anything.

THE WITNESS: It's always a lot, not always. Occasionally, we'll see fetal death from just the other medications that we use. I think probably once or twice in the past year, I have seen where we would have, the next morning, we would have a fetal demise, but that is very rare.

[p. 189] THE COURT: Now, can you give me a number or a percent of how many people or how many patients are we talking about who are then have a live fetus in utero that it's medically inadvisable for you to use the injection to terminate the life of the fetus, and you begin with the intention of doing an intact D & E. Can you give me a number or percentage?

THE WITNESS: I would say that in 1966 that number would have been –

THE COURT: In '96?

THE WITNESS: Excuse me, 1996, that number would have been a hundred, probably 180, 190 patients.

THE COURT: Okay. Now, you are gowned up, and my understanding is, if you can, you will – You will cut the umbilical cord at some point if you can reach it?

THE WITNESS: Yes, sir.

THE COURT: And if I understand further that that will, at some point, cause fetal demise?

THE WITNESS: Yes, sir.

THE COURT: Now, I understood you to say you don't know when fetal demise will occur even when you cut the umbilical cord?

THE WITNESS: No. I know the fetal heart will stop in probably 6 to 10 minutes, 90% would stop, but I think, you know, if you were to check at the cellular level, there is [p. 190] still fetal life there.

THE COURT: And typically, when you cut the umbilical cord, would you wait the six to 10 minutes?

THE WITNESS: No, sir, because as soon as you do anything to the uterine contents, we've already been giving drugs that cause uterine contractibility. Then once you rupture the membranes and go in and start, then every delay of even a minute, you still have some oozing of blood, some bleeding even not from the maternal circulation through the placenta, there is still some active transfer of blood there, so you're losing maternal blood just by waiting, even if you divide the cord, as well as fetal blood. I don't think there could be proposed an advantage to waiting.

THE COURT: At least an advantage for the maternal mother?

THE WITNESS: For the maternal mother.

THE COURT: Sometimes you can't cut the umbilical cord because you physically can't reach it?

THE WITNESS: Sometimes, exactly. You can't reach it, more frequently, because as soon as you rupture the membranes, part of the fetus spontaneously presents through the cervical os, either an extremity or the skull, and then you can't get around it to get to the cord, or you could, but you're running the risk of perforation and manipulation that is not really ethic indicated.

[p. 191] THE COURT: In those situations in which you either cut the umbilical cord, or you can't cut the umbilical cord, if the fetus presents in a way that is easier for you to extract the fetus whole but for the head, you will do that, is that right?

THE WITNESS: Yes, sir.

THE COURT: And you do that manually with forceps and your finger at some point, is that correct?

THE WITNESS: That's correct.

THE COURT: Of those 180 that we talked about, what percentage, or if you can suggest one of that number, are presented feet first up to the head, so-to-speak? Can you give me a sense? Is it half of them, a third of them, more than that?

THE WITNESS: The ones that come out intact, I'm saying we are talking probably 10% of 200, say, 20 of them. That's already eliminated the transfer of slides, because I would have taken them down from being intact, probably 50-50. I think it would be an even split whether the skull is first or the feet are first.

THE COURT: So in raw numbers, that's how many.

THE WITNESS: Probably 10.

THE COURT: And what I just described is what you would prefer to do if you could, if the fetus presented itself in a position within the uterus, you would prefer to [p. 192] do that because in your opinion, that's the safest way of aborting a fetus using that D & E procedure.

THE WITNESS: If you have the adequate dilation and you have the fetus present feet first or skull first, and just this last Saturday, we had an exact 19-week patient with a skull impacted in that we were able to just use a tenaculum and make a small laceration in the skull. It spontaneously expelled the cerebral contents, and the fetus passed instantly out of the vagina.

THE COURT: And when you did that, was the body of the fetus saved for the skull in the vaginal cavity?

THE WITNESS: No. That was the opposite. That one was skull first, and the only thing we opened was the portion of the skull that was outside. There was a portion of the skull outside of the vaginal cavity, and we made an in session [sic] in that and extracted the cerebral contents, and the rest came out.

THE COURT: But if you had your druthers, if you could design a presentation, it would be, am I right to say, that it would be that you would have the fetus presented through – well, presented feet first?

THE WITNESS: I think the feet-first presentation you can do with the least amount of dilatation because of the way that you can pull the shoulder down one at a time and get the arms out one at a time instead of

two, then get to the [p. 193] base of the skull with less dilatation than you can. I think that's the absolute safest scenario.

THE COURT: And that's what you would hope to do as you begin the procedure?

THE WITNESS: Yes, sir.

THE COURT: Counsel asked you about your experience, and I want to ask you a couple of questions in that regard too. My understanding is you were with the Air Force, is that right?

THE WITNESS: After my graduation from undergraduate school, I went on active duty as the medical administrative officer in the Air Force. I remained on continuous active duty for 21 years. During that time, I went – I was selected through candidate program and went to medical school while in the Air Force and then did my internship and residency while in the Air Force, and my final assignment was at Offutt Air Force Base from 1978 to 1985 as chief of surgery there. Well, I didn't come as chief of surgery, but I ended up as the chairman of the department.

THE COURT: As chief of surgery, what does that mean?

THE WITNESS: Well, I was, when I arrived, I was a general surgeon, okay. Then I was promoted to the chief of the department, being I was over the other general surgeons that were there, and then I was finally promoted to chairman [p. 194] of the department of surgery which was OB-GYN, orthopaedics, general surgery, and the emergency department came under that too.

THE COURT: How many physicians did you supervise?

THE WITNESS: Twenty-five probably, 20.

THE COURT: Now, when you were with the Air Force, I take it you learned how to do abortions in the Air Force?

THE WITNESS: That's true. I was in a civilian hospital on rotation. I didn't actually do any while I was on – I was on active duty when I did them, but I was not in an Air Force environment.

THE COURT: All right. When you were in active duty, were you permitted to do abortions in Air Force hospitals?

THE WITNESS: No, sir.

THE COURT: All right. I believe that's all the questions the Court has. Counsel, any follow up?

MR. HELLER: Just one or two, I believe, in connection with the Court's questions.

THE COURT: Go ahead.

REDIRECT EXAMINATION

BY MR. HELLER:

Q First, you indicated that you intend, in the category of procedures, between about 14 and 19 weeks, to start out hoping that you are going to be able to do the safest [p. 195] procedure which involves feet-first presentation and intact removal, but that that doesn't always

happen. In fact, that may only happen in about – in less than 20 cases.

A Ten percent in '96.

Q Instead, when you don't get that ideal result, is it correct to say that you end up removing portions of the fetus instead of removing it intact?

A Yes, sir.

Q Do you remove the portions of the intact fetus while the fetus is still alive?

A Yes, sir.

MR. HELLER: Nothing else, Your Honor.

THE COURT: Counsel?

MR. SMITH: Nothing else.

THE COURT: Counsel?

MS. WALZ: Nothing.

THE COURT: Thank you, Doctor you may step down. Counsel, you may call your next witness.

MR. HELLER: Thank you, Your Honor. Plaintiff calls Dr. Jane Hodgson.

DR. JANE HODGSON, PLAINTIFF'S WITNESS, SWORN

THE COURT: Counsel, you may proceed.

DIRECT EXAMINATION

BY MR. HELLER:

Q Thank you, Your Honor. Would you please state your [p. 196] name?

A Jane E. Hodgson.

Q Before I begin my questions, I just wanted to give you some of the documents that I may be referring to.

A I'm afraid I'm going to have to ask you to speak a little louder.

Q Okay. The exhibits I'm giving you are Exhibit 7 and Exhibit 14 and Exhibit 19 and a copy – This isn't an exhibit but it's a copy of the Nebraska law at issue in this case.

A Um-hm.

Q I will try to speak into the – more clearly into the microphone. Is that better? Can you hear me better?

A That's much better. Should I use it too?

Q That will be fine, I think. Can you tell me, what is your profession?

A I'm a physician, obstetrician, gynecologist.

Q Are you board certified in any specialty?

A In obstetrics and gynecology.

Q When were you board certified in obstetrics and gynecology?

A I was certified in 1949.

Q Are you a member of the American College of Obstetricians and Gynecologists?

A Founding Fellow.

Q One of the exhibits I gave you, Exhibit, I believe it's [p. 197] – Which one is your CV? Do you have your –

THE COURT: Exhibit 14, counsel.

THE WITNESS: Number 14.

BY MR. HELLER:

Q Can you identify Exhibit 14?

A It's my curriculum vitae.

Q And is it, to the best of your knowledge, accurate?

A I beg your pardon?

Q Is it accurate?

A I believe so. Yes.

Q Have you published any articles on abortion?

A Quite a number. I haven't counted but probably 50 to a hundred are on that subject.

Q Have you – How many abortions have you performed?

A Well, I have performed or supervised at least 30,000 as director of a number of clinics throughout the country since *Roe v. Wade*.

Q Have you also delivered babies in your practice?

A Yes, prior to – in the pre-*Roe* period and subsequently to, I have delivered at least 5,000 babies.

Q Did you perform any abortions prior to 1973 when the Supreme Court issued the *Roe v. Wade* opinion?

A I performed an abortion in 1970 for the purpose of challenging Minnesota's abortion law, performing an abortion on a patient that was 12 weeks pregnant and had been [p. 198] diagnosed with as having had Rubella during the first month of her pregnancy.

Q I will return to that in a moment. Prior to the abortion you performed in 1970 –

A Right.

Q – had you performed abortions before that in your career?

A Well, only in very unusual situations with consultation with our abortion committees at the hospital, cases of women that where it was necessary to save a life or in cancer patients or something of that nature.

Q And were those abortions performed in Minnesota?

A Yes.

Q Where are you currently licensed to practice medicine?

A I'm sorry?

Q Where are you currently licensed to practice medicine?

A I'm currently licensed in Minnesota and in the District of Columbia, and that's it for now.

Q In 1970 when you performed the abortion for the woman who had had Rubella, what was the result of your performing that abortion?

A Well, I sought help. I went to the federal court prior to performing the procedure asking them for an injunction to prevent my being prosecuted under the law. I was so frustrated with the hypocrisy around the whole abortion [p. 199] situation, the fact that there was two levels of patients and no equal justice for all and the need for abortion services for women. I had been practicing under that since 1947, and I saw the beginning to feel the necessity for a legalizing abortion in the United States. I had spent a lot of time overseas in Third World countries where abortion was illegal, and I saw the problems that were common to countries that did not have legalized abortion, and so I – The federal court failed to give me any response, and time was passing, and I didn't want to – In those days we were afraid to do abortions over 12 weeks, and so I went ahead and openly performed it with consultation from a number of my colleagues, and then I was indicted and prosecuted and convicted, and I did not have that conviction overturned until, oh, two weeks after *Roe v. Wade* when the Minnesota Supreme Court had heard my appeal, but they did not hand down any decision for all that time.

Q What, prior to 1970 when you did occasional abortions when a woman's life was in danger, what method was the prevalent method in the United States for abortions?

A Well, every specialist in the field did just the ordinary D & C procedure which we called the sharp

curettage. We didn't have any suction equipment. It was not even discussed in the United States. It was popularized in Europe, in Eastern Europe mainly, and in England, and it was [p. 200] first published in our American literature, we saw articles concerning suction in 1967, and I became aware of it at that time, but there was no equipment available. You couldn't – It wasn't made in the United States. It had to be imported from London.

Q After 1970 and the abortion for which you were convicted, did you continue to perform abortions at what point after that? Did you continue to perform abortions?

A Well, no. Well, I could not perform them in Minnesota. I was on probation, and – but I was offered the job of director at a preterm clinic in the District of Columbia. They had recently opened one of the largest abortion clinics on the East Coast, and I went out there and took over the directorship and indirectly learned very quickly how to do suction abortion, and we were doing about a hundred a day there, and I remained there until a year following *Roe v. Wade*. We did a great deal of research on complications and on technique, and we were able to disprove some of the fallacies in regard to abortion, the dangers of abortion. We had had it so drilled into us all through the years that it was a very deathly thing to do, and that just invading the pregnant uterus was extremely risky. So we had an ambulance down in the basement, and we were all prepared for all these complications, but they never occurred, and we kept very careful records, and we published our results, and within a [p. 201] couple of years, we established the safety of the abortion procedure.

Q At that time, you were using the suction method of abortion?

A Using the suction, yes. We had to import the equipment from Rocket of London.

Q During your time at the preterm clinic in Washington, up to what stage of pregnancy did you perform abortions?

A We theoretically were cut off at 12 weeks, but we didn't have an ultrasound in those days, and so our sometimes our estimates of gestational age was definitely off, and we would find doctors would get involved in procedures that were further along. The pregnancy might be 14, 15, 16 weeks, and so we were almost forced to go a little bit higher just from human error.

Q What procedure – Did you use a different procedure for 14 or 15 week pregnancies, or did you also use suction?

A Well, we just had the suction then, and that was all we did. We could do modified types of D & C's, but we would try things, we were, for quite for a time, it was popular to get larger cannulas up to size 16 which would be the size appropriate for a 16-week pregnancy, and but these large cannulas were no improvement because they were dangerous. You have to go into the uterus with the cannulas, and obviously, a big, a larger size cannula was more of a danger [p. 202] as far as uterine perforation, so I think on the whole, it has been abandoned throughout the country. They rarely use the larger size. They go right into the D & C procedure.

Q What would a woman, back at that time, let's say, between 1972 and 1974 who needed an abortion later than 14 or 15 weeks, what procedures were available to women at that time?

A Well, they really had to wait until they – they were out in general. They were told that they would have to wait, and then at 18 weeks, they might, in some states, would get an induction where it was legal, but, of course, in many states it wasn't legal. Abortion was still illegal.

Q Well, until what point they would have to wait, to what point to get an induction?

A Induction.

Q How late, how far along pregnancy?

A They would have to be far have a large enough amniotic sac so that it's easy to get into it and withdraw amniotic fluid, and that is usually not before 16 weeks.

Q What method of induction was used in the early 1970's? What type of induction was used?

A They were mainly salines.

Q And are saline abortions, saline inductions, still used in the United States?

A Saline is almost, I think it's obsolete in many places [p. 203] considered so, because of the danger. It's quite dangerous and has to be very carefully used in order to prevent reaction.

Q Where are we getting that from? Oh, there it is. After 1974, where did you work next?

A I returned to my home in St. Paul and took over as director of the Fertility Control Clinic which I actually established at St. Paul Ramsey Medical Center which is a teaching hospital connected with the University of Minnesota, and there I became interested in the more advances [sic] terminations and concentrated on induction procedures, also directed the clinic at which first trimester abortions were performed, and we provided sterilizations and did operations, ectopics and all the related type of problems.

Q What type of induction procedures did you use there?

A We used we concentrated on extra amniotic Prostaglandin F2 Alpha. It's a system that promoted by Dr. Bigdeman from Sweden and a technique in which the Prostaglandin is very carefully instilled through a Foley catheter in the cervix, and as the solution enters the extraamniotic, extraamniotic cavity, the cavity around the – between the uterine wall and the amniotic sack, so it was administered at a very slow rate and very well controlled by a Harvard pump which would very carefully control the rate at which the drug was administered in the patient, and if any of these complications were [p. 204] reported now, the high blood pressure and the idiosyncrasies that some patients will have to the drug, we could stop it instantly, and I am really amazed that they even talk about using it intramuscularly because I know that is dangerous, and I'm surprised that they don't use this other technique.

Q Did you use any other techniques at Ramsey, St. Paul Ramsey for doing second trimester abortions?

A Well, the same time we were doing D's & E's, D & E's by the usual method, the standard method, and we were doing those up till probably – we didn't encourage them over 18 to 20 weeks because it's always felt there was a great deal of intrauterine manipulation with sharp instruments, and they were hazardous, particularly in a training program where you were trying to train residents and interns, so induction was really safer for that type – for training purposes.

Q After the period you worked at the St. Paul Ramsey Hospital, where did you work next after that?

A We spent a year with Project Hope in Egypt at the university there.

Q After you returned from Egypt, where did you work?

A Then I spent some time in San Francisco at the University of California at San Francisco in their – I took over the Fertility Control Clinic there, and interestingly, in California, the attitude – the policy then was no inductions at all. They did D & E's up to 25 weeks.

[p. 205] Q And did you also do D & E's up to 25 weeks?

A Oh, yes, yes. I was in charge of that program. I took temporarily while the director was on – what do you call it – leave.

Q Who was that person who took leave?

A Dr. Darney, Phillip Darney. He took a sabbatical.

Q Do you have an opinion about whether currently, an induction procedure, say, at 18 weeks, is more or less safe than a D & E procedure at that point in gestation?

A Would you repeat that?

Q I wanted to get you to compare the safety –

A Um-hm.

Q – of a D & E and an induction at 18 weeks pregnancy. Do you believe they are equivalently safe, or is one safer than the other?

A Well, the figures, of course, have always cited the higher complication rate for the induction, but I think you've got to specify what – which medication you're using in your technique and the technique. Probably, I personally would feel that, well, again, I would have to see the patient to really –

Q What are the – Are there advantages, aside from the safety issue, are there advantages or disadvantages for a D & E?

A From the patient.

[p. 206] Q Yeah.

A That's what I meant. Some women will tolerate the induction procedure very readily because, particularly if they have had a number of pregnancies and gone through labor and they know what to expect, whereas women who have never had a child, the young teen-ager isn't going to do well with an induction where they are forced to be inactive, and it's the uncertainty of it, and all they would much rather, I think, go through the D & E.

Then you must take into consideration the condition of the cervix, the patient's general health and the rest of it, so I couldn't just off the cuff say one is better than the other. I think you have to adjust it to the patient and your setting, and the hospital setting, and the hospital care is terribly important in the induction, the kind of nursing care that you have.

Q Can you describe for me, in general, what a physician like yourself would do in terminating a pregnancy by dilation and evacuation, by D & E? What does that involve?

A Well, first of all, the most important thing is the dilatation and the cervix, and that it be adequate, and that is – We first started laminaria back in '72 in Washington, and gradually the use of laminaria spread, and it has been extended over a three-day period. I think Dr. Herron promoted that. He would often insert it three days in a row, and they would come in 24 hours, and then return the next [p. 207] morning and the laminaria would be removed and replaced with additional laminaria, and that would be done for three different times, so that there was a total of 36 hours, and then come in, then the procedure would be performed. By that time, dilatation would be achieved anywhere from two to three, four inches even in diameter, and – the cervical opening, and then the operator will – may or may not use the cervical block. Usually not if the dilatation is adequate and varying types of sedation. In San Francisco, we always gave patients intravenous Fentanyl which didn't really put them to sleep, but it gave them very good temporary pain relief, and the membranes are ruptured, and the – and then with especially the suction is applied to remove all the amniotic

fluid and what you can with the cannula, but obviously, then, you are left with the fetus to remove, and this was done ordinarily piecemeal by dejoin – The fetus is removed, and some of it, if the uterus is contracting, why, it will voluntarily, there will be expulsion of fetal parts down into the cervical canal, and it will be easy to grasp them and remove them, but some people will start using Pitocin at that time just to aid in the performance.

Q When you talked about ordinarily, you would remove parts, you began removing the fetus.

A That's right.

Q And what sort of instrument do you use to remove parts [p. 208] of the fetus?

A We always favored the Sopher forceps. They are very light weight and were designed by Dr. Sopher of London just for this purpose, or many, there are a number of other forceps that are good, and some people just use plain ovum forceps, but they aren't bent properly. They are not strong enough really.

Q When you begin the D & E, is the fetus alive?

A Well, that may be. I mean, it can be or it may not be. After the three-day laminaria procedure, many women will rupture membranes themselves, or may go into early labor, and there will be no fetal heart, but during this procedure, we are not constantly checking fetal heart because it has been understood that the demise of the fetus will take place, and I think it's very hard often on the woman patient to keep emphasizing the fetal heartbeat, and so in a situation like that, we just don't check it, so I don't know. I might not – I wouldn't

normally deal with the time when and if the fetus expired. It would depend on the age, of course, of the fetus too. It wouldn't matter if it was up – if it was below viability. If it was over viability, that's a different point.

Q Well, let's take the example of previability or restrict our discussion to previability. If you were looking at the fetus through ultrasound just before you started the [p. 209] procedure, would you be able to tell if it was still alive?

A Well, it would depend on your equipment. We didn't have equipment during procedures until relatively recently. Now, of course, they are common in every clinic, and almost everyone is doing any number of procedures, has ultrasound available some use them routinely. Other doctors don't, as far as determining whether they are alive or not. That, too, is not absolute.

Q Well, if you, could you see through ultrasound whether the fetus had a heartbeat?

A Probably if the patient wasn't too obese.

Q In doing the D & E that you're talking about, what's typically, what typically actually is done with the forceps? Can you describe how the forceps are used?

A The forceps, you grasp the fetal parts, and you often don't know what they are, and you try to pull it down, and it's – It's very crude. It's simply all there is to it.

Q Well, can you describe in more detail if you were doing a D & E without ultrasound?

A Um-hm.

Q How would you know what you were grasping with the forceps?

A You don't sometimes. Maybe you could tell with the index finger of the other hand, or you could feel it, try to determine the position, and you try to bring it down, you try [p. 210] to bring down an extremity, but you are not always able to do that.

Q And –

A You may want to dilate further if you are unable to be successful in getting a part down.

Q In getting a part down, does the part actually, does the fetus come, break into pieces, or does it remain in one piece during the D & E; in other words, are you removing it piece-by-piece or in one piece?

A You have to remove it piece-by-piece.

Q What's the typical size of a piece that would be removed?

A Oh, they vary so much.

Q Just some examples of what might be removed?

A Well, the four extremities and parts of the skeleton of the spinal column, in the cranium, of course, is the largest part, and that is always at the back of your mind that you – about getting the cranium because that's the largest diameter to pass through, and you may have to reapply the forceps and actually capsize the head in order to get it through the cervix.

Q At what point during that procedure that you're describing, assuming the fetus starts out living with a heartbeat, at what point does the fetus undergo demise?

A Well, that's anybody's guess. Probably as soon as you [p. 211] have it, probably some bleeding takes place when you remove the extremities, or you may cut – The cord can be cut and it can exsanguinate. There are a number of ways.

Q Could you be removing an extremity, let's say a foot?

A Um-hm.

Q And the fetus could still have a heartbeat?

A That's right.

Q Have you ever done a procedure, a D & E procedure where you removed the fetus intact, in one piece?

A Yes, that does happen sometimes without planning it that way, without any intent, and, of course, it's kind of a victory. It's always much, much shorter, and, you know, you don't worry about having left parts behind, and that will happen where you have adequate dilatation and a contracting uterus. It's very helpful.

Q You mentioned first, you mentioned that parts won't be left behind.

A Um-hm.

Q If you have it out intact. What's the danger of parts being left behind?

A Well, that can be horrible complication. The patients can get infected or bony splinters can come – can

cut the uterine wall and perforations are common, uterine perforations are fairly common in this procedure, and that is one reason that I think I've always been conservative about [p. 212] doing them beyond the 18th to 20th week.

Q Well –

A I think that the induction can be made as safe.

Q If you were to remove the fetus intact, in one piece, would that require more or less insertion of instruments?

A It would be much less, and the less instrument manipulation, of course, the higher your safety.

Q Do you have an opinion, then, about the relative safety of an intact D & E versus a nonintact?

A Yeah.

Q What is your opinion?

A Well, I think it's, hopefully, I haven't personally done any with intent, so I don't know how hard, difficult it would be, but from what I read about it and what I have seen, I think that it's probably an advance in technology and may well prove to be an improvement over what we have to – over what we have been working with up to now, and so I have been very interested in Dr. Haskell's work ever since he first published in '92, I think it was, his article, and the few that have followed his technique and are reporting on it, the reports are quite favorable. I personally have had no contact with that myself.

* * *

[p. 213] THE WITNESS: Yes, I have seen this before. This is the AMA report on intact D & X, is it not?

BY MR. HELLER:

Q Well, it's a portion of it.

A Yes, I recognize it.

Q It's a portion of it. If you would look at the last paragraph on that page?

A Yes.

Q Could you read that paragraph to yourself and just tell me whether you agree with it?

A I do very much.

[p. 214] Q Do you know, Dr. Hodgson, do you know if the – So you agree with that last paragraph?

A Yes.

Q Do you know if the American College of Obstetricians and Gynecologists has taken a position on intact D & E abortions?

A Yes. They realize – they have stated that they felt that there were some unique situations in which it was indicated, and –

* * *

[p. 215] Q If you turn to the second page of that document, does it express a conclusion about intact dilatation and evacuation? Does it reach any conclusion?

A Yes. It points out, it's one of the methods available in the situation where you're terminating a pregnancy to save the life or preserve the health of the mother. I assume this is a case of a viable fetus.

Q Well, I'm not sure if it is. What I want to see, is there anything in there that indicates whether the procedure, this type of procedure is considered safe, if you want to take a moment to look it over. Well, actually –

A It points out that the intact D & X is one of the methods available in performing D & E's, and it could – it may be the best or the most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor in consultation with a patient, based upon the woman's particular circumstances, can make this decision.

Q Dr. Hodgson, do you agree with that statement by the [p. 216] American College of Obstetricians and Gynecologists?

A I do.

Q If you would now turn to the Nebraska law which I gave you a copy of, I hope. Do you have a copy of that?

A I do.

Q Could you turn to page four of that document? On that page, there is a definition of partial-birth abortion. First, I want to ask you, is partial-birth abortion a medical term?

A No.

Q Is it a term that you have ever seen in any gynecological textbook or articles?

A No, I never have.

Q Looking at this definition, and if you want to take a –

Why don't you take a moment to read it through?

A I have read it many times.

Q All right. If the types of procedures described here were illegal, what – Well, let me ask you, what types of procedures do you think this definition might cover?

A About 95% sent [sic] of abortion procedures, I think, really, if you applied – if you applied it to them.

Q For example, in a –

A Well, in a first trimester, you are frequently – you are drawing fetal parts even if the cord – even in more advancement, if the cord prolapses, you have got part of the [p. 217] fetus in the vagina when the fetus is still alive, and in the early trimester, you've got the fetus, the embryo going through the suction cannula and into the vagina, and we don't know when, of course, that embryo is no longer living, but we wouldn't be able to determine that very well, but it takes place, and so and as you go further along the stage of gestation, why, the same thing can apply at anytime during an abortion procedure. The cord or part of the fetus can come, enter the vagina spontaneously. You would have no control over it.

Q One of the discussions in this case has been about the level of intent required to violate this law. How many

abortion methods does the physician have the intent of taking a portion or the entire fetus through the vagina while it's still alive?

A Well, all of them. They have the intent to – It is understood, all forms of abortion, that there is going to be fetal demise, and when it happens is extremely variable, and so I fail to understand the purpose of the partial-birth abortion law because why they insist that it be done when the fetus is still alive, why that makes it any different or more or less ethical.

Q Is it – Is this a procedure that could be done when a fetus is dead?

A Well, then the law apparently doesn't apply. I mean, [p. 218] the partial-birth abortion ban would not apply to a dead fetus.

Q Are there situations where –

A But how does that make it any different? I don't understand why a person, a doctor would be exonerated if he produced that, killed that fetus before and – or after.

Q Well, would there be any different risk to the woman if this procedure or the partial-birth procedure were done with a live versus a dead fetus? Is there any difference to the woman's health?

A Not that I know of. I mean, not on the face of it, no, not unless there is some details that I don't know about.

Q You talked a little bit about the first trimester abortion.

A Um-hm.

Q And its coverage under the law. In the D & E abortion, not the intact one but the standard one or the traditional one, is it the doctor's intention to remove a portion of the fetus before killing it?

A I don't think the doctor – If this is a previability case, I don't think that the doctor is even thinking about it because it's inestimable. The demise is inestimable, and this is just the job to be done.

Q Well, what I'm trying to ask is, when the doctor sets out to do the D & E, say, at 15 or 16 weeks?

[p. 219] A Um-hm.

Q The doctor intends to take what is a live fetus and end up with a dead fetus?

A Right.

Q And in going from one point to the other, the doctor intends to remove portions of the fetus through the cervix?

A Right.

Q And if the doctor, for example, removes a foot first, the fetus may well be alive?

A Right.

Q If, on the other hand, the doctor removes the head first, then the fetus is not likely to be alive, isn't that right?

A It would depend on if it was a very easy delivery if he performed with forceps, why, the fetus might still be alive.

Q What do you consider to be a living fetus? Do you consider that to be having a heartbeat or living tissue? What is your – What would be your way of defining that?

A Well, that certainly is a debate. I think the heartbeat is probably the best that we can – indication we would have, but it probably tapers off very slowly, or it can be a very common goal sort of thing, too, because I would think that during long labors, when we know by the monitors on the infant, that the death can be quite slow and dragged out. We can tell by the fetal monitors that it's very protracted, but [p. 220] the same thing may happen with the D & C, but it's a quick procedure and certainly they exsanguinate or they suffocate or whatever, something happens, and they expire.

MR. HELLER: I have no further questions, Your Honor.

THE COURT: Counsel, what are the doctor's travel plans?

MR. HELLER: The doctor will be available in the morning if the Court would prefer to continue in the morning.

THE COURT: Mr. Smith, what would you prefer?

MR. SMITH: I think I'm going to be pretty brief, 10 minutes, I hope.

THE COURT: That's fine. Would you like to go now?

MR. SMITH: I would just as soon go now.

THE COURT: Do you have a sense –

MS. WALZ: I don't anticipate having any questions at all.

THE COURT: Why don't you inquire then, counsel?

CROSS-EXAMINATION

BY MR. SMITH:

Q Dr. Hodgson, can you hear me okay?

A Not too well. I'm sorry.

Q If you can't hear me, you'll let me know, won't you?

A Yeah, I will try.

Q When did you last perform an abortion yourself?

[p. 221] A About one year ago. I have had spinal surgery since that time twice, and I have had to forego any actual surgical procedures.

Q And were you actively performing abortions up to that point in time?

A I was, um-hm.

Q Now, just to understand these different medical organizations, Mr. Heller showed you this statement of policy from the ACOG?

A Yes.

Q And is that a different organization than the American Board of Obstetrics and Gynecology?

A Yes, it is.

Q And is the American Board of Obstetrics and Gynecology, is that the board that certifies physicians in that specialty?

A That's right.

Q And a person who belongs to the American Board of Obstetrics and Gynecology has to go through some process to be certified as a specialist?

A Oh, yes.

Q The American College of Obstetricians and Gynecologists, do they actually, is there a certifying process where one –

A No.

Q Now, as far as – You're familiar with the Center for [p. 222] Reproductive Law and Policy in New York?

A Yes.

Q Are you affiliated with that organization?

A Am I what?

Q Affiliated. Are you on the board of directors?

A I'm on the board of directors. I have been for about a year.

Q And the Nebraska law on partial-birth abortion, is that similar to the proposed federal law on partial-birth abortion, if you know?

A Very similar.

Q At least as far as the definition of a partial-birth abortion?

A Right. It does not include, I don't think, the amendments that the AMA put on it.

Q And as far as the federal partial-birth abortion law, have you been active in any manner in opposing the enactment of that legislation?

A Just not specifically, no. I mean, I belong to a lot of organizations that are opposed to it, but I haven't done anything specific.

Q Okay. Are you familiar that your picture appeared in an advertisement for the *New York Times* this year in connection with the Center for Reproductive Law and Policy, essentially saying why the proposed federal legislation would be bad [p. 223] medicine?

A Yes, I'm aware, and that was primarily in protest of the AMA restriction of their support for and the fact that the AMA supported a law which would criminalize the surgical procedure regardless of what it was. It wasn't particularly, as far as I'm concerned, the partial-birth abortion act, but was the fact that they would criminalize the surgical procedure by people, individuals in Congress who were totally uninformed about what they were doing, and it was something I felt very deeply about.

Q Would it be an accurate statement that the AMA has gone on record, then, as supporting the proposed federal legislation banning partial abortion?

A I'm sorry?

Q Would it be an accurate statement that the American Medical Association is on record as supporting the federal legislation banning partial-birth abortion?

A Supporting it, you said?

Q Yes.

A Yes, to my dismay, that's true.

Q And you –

THE COURT: Just a minute. Just a minute, counsel. Is there going to be any proof of that, counsel, aside from this witness's understanding of her belief?

MR. SMITH: Well, that's a good question, Your [p. 224] Honor.

THE COURT: The reason that I ask, I'm willing to allow hearsay statements that explain an expert's beliefs, to understand the expert's belief. I'm not willing to allow an expert to give hearsay testimony to prove the truth of the matter asserted.

MR. SMITH: Okay.

THE COURT: If you are offering this testimony to prove the truth of the matter asserted, just as counsel's trying to get in the back door Exhibit 19 or whatever this thing is, I'm not receiving it to prove the truth of the matter asserted, only that this witness thinks that this is part of the reason for her opinion.

MR. SMITH: I would offer it for the purpose of showing what the witness's personal views and beliefs are. Whether or not that, in fact, is the case of the AMA, I

won't offer it for that point, but to at least explain her personal views and beliefs and what she advocates.

THE COURT: Thank you. With that understanding, that helps me. Thank you.

MR. SMITH: Nothing further, Judge.

THE COURT: Counsel?

MS. WALZ: I have no questions.

THE COURT: Counsel?

* * *

[p. 232] THE COURT: Good morning. We're on the record again, continuation of our preliminary injunction hearing in Carhart versus Stenberg. Is counsel for the defendants – Are counsel for the defendants ready to go?

MR. SMITH: Yes, Your Honor.

THE COURT: You may proceed.

MR. SMITH: We would call Dr. Christopher Riegel.

DR. CHRISTOPHER RIEGEL,
DEFENSE WITNESS, SWORN

THE COURT: You may proceed.

DIRECT EXAMINATION

BY MR. SMITH:

Q Would you state your name?

A Christopher Joseph Riegel.

Q And what do you do for a living?

A I'm an obstetrician and gynecologist and infertility specialist in Dallas, Texas.

Q And as far as just giving your background history, could you give us background on your college education; in other words, where you went to school, when you graduated, what degrees you obtained?

A I went to Southern Methodist University where I got a chemistry degree with honors in 1983 and also a sociology degree. They were both BA's. I went to medical school at the University of Texas Hall Science Center in San Antonio from ['83] to '87 where I got my medical degree. I did a [p. 233] one-year internship in pediatrics at Children's Medical Center in Dallas from '87 to '88, and then from '88 to '92 did a four-year residency, internship and residency in Obstetrics and Gynecology at the Parkland Hospital in Dallas at the University of Texas, Southwestern Medical School. In '92, I went into private practice in Dallas.

Q Now, the residency program that you completed at the Parkland Hospital, do you know whether or not that residency program has any national reputation?

A It's considered one of the top two or three OB-GYN programs in the country.

Q And you went into private practice in 1992, you say, in Dallas?

A Yes.

Q And have you practiced medicine continuously since 1992 in Dallas?

A Yes.

Q And do you practice in any specialty area?

A My practice is probably about 60% obstetrics, 30% gynecology, and about 10% infertility at this point.

Q And are you certified by any recognized specialty boards?

A Yes, I'm a Diplomate of the American Board of OB-GYN.

Q How do you become a Diplomate in the American Board of OB-GYN?

[p. 234] A At the end of your residency, you take a written examination. When you pass that, you take – When you have been in private practice a couple or three years, you take an oral examination, and you become certified if you pass the oral examination.

Q And when did you become board certified?

A I took the examination in November of '95.

Q And became certified then?

A Right thereafter, within a few days of that.

Q Do you have hospital privileges in any hospitals?

A I have active staff privileges at Columbia Medical Center of Plano in Plano, Texas, Presbyterian Hospital of Plano in Plano, Texas, and I have courtesy privileges at Trinity Medical Center in Carrollton which is an adjoining. Those are all suburbs of Dallas.

Q What's the difference between hospital privileges and courtesy privileges?

A Full active staff privileges basically means that you do quite a bit of work at that facility, necessitating active privileges, where you attend meetings both for your department and for the entire hospital staff, and you take call responsibilities in the emergency rooms and in labor and delivery, versus courtesy privileges is where that you can do procedures at the hospital. However, your role at that particular hospital is limited, and just because you don't do [p. 235] very many procedures there, you don't need to be on call for the ER and go to all the meetings. It's kind of a status where it's not as restrictive on your time, basically, but you still have basically full privileges. You are just not there very much.

Q And in your practice, do you do surgical procedures?

A Yes.

Q And these would be surgeries related to what?

A Well, all manners of gynecologic surgery, and then obviously cesarean sections to deliver babies, and other infertility surgeries to open the people's fallopian tubes and things of that sort.

Q And I assume you're licensed to practice medicine in the state of Texas?

A Yes.

Q Are you licensed in any other states?

A No.

Q Now, as far as what you actually do in your medical practice, do you do medical procedures which involve removing a live fetus from the uterus?

A Yes.

Q And do you do medical procedures which involve removing a dead fetus from the uterus?

A Yes.

Q And are there lay terminologies that apply to removing a [p. 236] live fetus from the uterus and removing a dead fetus from the uterus as far as what you do?

A Right. Obviously, removing a live fetus from the uterus is a vaginal delivery of a live baby. The removing of a dead fetus, that is considered the delivery of a fetal demise, is what that's called.

Q But as far as what you do, do you do abortions?

A No, I do not.

Q What you do would, I take it, wouldn't involve in the lay concept of a miscarriage?

A Exactly.

Q And when we are talking about a miscarriage or removing a fetus that's dead, when do you consider a fetus dead?

A I believe it's generally accepted the fetus is considered dead if the heart has stopped beating.

Q And that fetus would be considered alive, then, when?

A If the heart is beating.

Q And when you say generally accepted, generally accepted by whom?

A Physicians.

Q And when you are dealing with removing a live fetus from the uterus, what you do as far as delivering a baby, whose health are you all concerned about in that situation?

A Well, we are obviously concerned about the health of the baby and also the health of the mother.

[p. 237] Q And when you're dealing with a miscarriage situation, whose health are you concerned about?

A The mother.

Q As far as the number of miscarriages that you've attended or dealt with, do you have any estimate of the numbers you've dealt with?

A I don't have an exact number, but it's in several hundreds.

Q And as far as the gestational ranges of the fetuses that you've dealt with in miscarriage situations, can you tell us what the ranges would be?

A Anywhere from a barely recognized pregnancy at five or six or seven weeks all the way up to a fetal demise at 37 weeks.

Q And would you agree that as a general principle, removing a dead fetus is more complicated the more advanced the weeks are in gestation?

MR. HELLER: Objection; leading.

THE COURT: It is leading, but with an expert, I'm going to give some of that. Overruled. You may answer, Doctor.

THE WITNESS: It's well known that the more further along a pregnancy is, the higher the gestational ages, the more difficult the procedure.

BY MR. SMITH:

[p. 238] Q Are you generally familiar with the medical risks and complications involved in removing a dead baby from the uterus?

A Yes.

Q Are you familiar with the medical procedures that would be involved in removing either a live or dead fetus from the uterus?

A Yes.

Q And are you familiar with the generally-accepted medical procedures performing abortions?

A Yes.

Q Are you familiar with the medical risks and complications and contraindications associated with the performance of abortions?

A Yes.

Q And can you tell us how you are familiar with the generally accepted medical procedures, the risks and complications and the contraindications associated with abortions?

A Well, just from during my training, reading, keeping up with the American College of OB-GYN technical bulletins, reading in Williams Obstetrics and Gabbe Obstetrics textbooks, and from time-to-time in my training at Parkland Hospital, there were medically indicated abortions that were performed while I was there in training that, as my role as [p. 239] the chief or most senior resident in labor and delivery, I would have to come in a situation where possibly the night before, a drastic fetal anomaly had been discovered in the high risk OB-GYN clinic, and the mother wanted to go ahead and terminate the pregnancy as soon as possible, so they would go ahead and start it that evening. By the time I took over the next day, it would still be going on, so I'm acquainted with what goes on.

Q And have you, in your practice or in your experience, for that matter, been involved with just treating patients who have been previously treated by physicians who have attempted abortions?

A Yes, I have a pretty extensive background there. Parkland Hospital is the county hospital in Dallas, and whenever there is a severe complication from an abortion attempted at one of the outlying abortion clinics, basically they send them to Parkland for us to fix.

Q Now, as far as the care that you would provide associated with a pregnant mother who intends to give birth to a child, do you – Does part of your care ever

involve injecting a needle into the uterus or uterine cavity?

A There is a procedure known as amniocentesis that is performed for genetic reasons early on in pregnancy, usually between about 13 and 18 weeks, and I have helped in those during my residency and performed those during my residency. [p. 240] Also, there are amniocenteses done near term to determine fetal lung maturation indexes to time the delivery of a planned C-section.

Q And the amniocentesis, can you tell us what the procedure actually is?

A Amniocentesis involves sonographically locating the position that you're going to attempt to put, place a needle. There usually, [sic] anatomically, nearly 100% of the time, 100% of the time in my experience, there is, when you're looking through the sonogram vision of the array of your field, you see the skin, the subcutaneous fat, the abdominal wall muscle, followed by pregnant uterus, okay? And what you do is a sonographic guided tap of the uterus with a very, very fine spinal needle, so what you do is, you have the transducer on the abdomen, and you after, you have sterilely cleaned the field with multiple rounds of Betadine –

Q The field being what? What is the field?

A The field is just a surgical field. Anytime you're doing an invasive procedure, you cleanse the area with Betadine and put sterile barriers around it so there is no – you lessen and nearly eliminate the possibility of an infection, and you put the sonogram in a sterile glove, and you place it on your sterile field on the patient's

abdomen where you're looking to find the place where you want to insert the needle, and then you watch, actually on the video [p. 241] screen, you watch where your needle is going, and you can see it perfectly.

Q And when you say the sonogram, is that what – How do you sonographically do that? Is there a name for the machine?

A Ultrasound machine. A sonogram is actually – I use the terms interchangeably, but it's an ultrasound machine, and the sonogram is the actual pictures you take.

Q And the amniocentesis, at least in your experience, has been performed at the weeks of gestation from 13 to 18 weeks?

A Oh, yeah.

Q And also later?

A Right.

Q And are there medical risks to the mother and to the fetus by doing an amniocentesis?

A Well, any time you do any type of invasive procedure, there are risks, but in the hands of a skilled operator, those risks are minimal. Your risk of an infection, say, from a genetic amnio between 13 and 18 weeks is about one in a thousand. The risk of an amniocentesis-related miscarriage overall is, and across the country and including in training centers where you know younger-level residents such as interns might be doing them, is one in 200 for all the different complications that can arise that might lead to a miscarriage. However, again, in

the hands of a skilled [p. 242] physician that has lots of experience, it's more like one in 800.

THE COURT: Mr. Smith, so you understand, the Court may not be clear that an amniocentesis is the same thing as injecting Digoxin into the fetal cavity, thoracic cavity, and if there is a difference, it would be helpful for the Court to know that.

MR. SMITH: I appreciate that. My questions, really, at this point, are more foundational with the expectation to get into that.

THE COURT: All right.

BY MR. SMITH:

Q As far as the risk that you've described from the amniocentesis, the risk of infection, if the risk turned into reality, in other words, the patient actually was infected, what's the complication, then, in just dealing with the infection?

A Well, what would happen, if a patient developed a severe infection from an amniocentesis-related infection, you, at that point, are going to do everything you can to protect the life of the mother, and depending on how severe the infection is would determine what you would do. If you get an infection inside the uterus that's a severe infection, there is going to be no way to really save the fetus, and so that would be considered an infected – basically an infected [p. 243] miscarriage that has been brought on by amniocentesis. Now, translating that and getting to the judge's concern, as far as procedure that's associated with an abortion which a physician would, through a sonogram or through the ultrasound, inject the

fetus or inject the, I guess, the fetal sac for a better term, with a substance in order to cause the fetal demise of the fetus, are you generally familiar with that type of procedure?

A I believe you're asking about like an installation procedure where they inject – would inject either hypertonic saline or hypertonic urea. I am familiar with that.

Q Would you be familiar with the procedure in which there would be an injection of Digitalis or potassium chloride in order to cause demise of the fetus?

A Yes.

Q Are you able to explain what differences, if any, there would be between that type of an injection procedure to cause the fetal demise for an abortion versus the procedure that you do which is the amniocentesis?

A The difference, to my knowledge, is that instead of looking for a clear pocket of fluid to remove fluid from, you would be –

Q And that's what you do in an amnio?

A That's what you do in an amniocentesis.

Q Go ahead.

[p. 244] A You would be looking for the fetal heart which is a pretty obvious anatomic structure on the ultrasound from – You can see it, ultrasoundwise, from five weeks on, but at, say, 13 weeks, 15 weeks, it's very obvious, and you're at any point past that, you are looking to put your needle, instead of into a pocket of fluid, like with an amniocentesis, you just direct it into the heart.

Q And if one wanted to cause the fetal demise other than by injecting into the heart of the fetus, do you have to hit the heart, I guess is what I'm saying?

A If you are looking to stop a heart by injecting potassium chloride or Digoxin, you need to hit the heart, yes.

Q Well, can you get an area within the uterine sac, I guess?

A Well, if you are looking to stop the heart, you want to inject the heart.

Q And at least based on your knowledge and experience, you believe that a skilled physician would be able to do that type of an injection and inject the heart at age 13 weeks on?

A Well, it's – The higher the gestational age, the easier it would be just because you're aiming at a large target but if you are – a larger target. But if you are looking at – if you restrict, yourself to 19 weeks and up, say, which is generally, if people are going to use that particular route [p. 245] to stop the heart of a fetus, that's generally when they do it, but could a person that was facile at instrumentation to do the procedure at 19 weeks do it on the 17th week or 15th week, the answer should be yes.

Q Thirteen weeks?

A You should be able to put it into the heart at 13 weeks, but that – I don't – That's not something that's generally done at that particular age.

Q Now, as far as the risk of doing the injection to cause the fetal demise, do you understand what I mean by that?

A Right.

Q Okay. Do you believe there would be a risk of perforating the bowel of the mother?

A The risk of perforating the bowel in an ultrasound guided procedure, whether it be amniocentesis or stopping the heart of a fetus, is virtually zero.

Q Is there a risk of injecting the mother rather than injecting the fetus?

A The risk of injecting the mother with Digoxin or potassium chloride in that procedure, in the hands of a skilled operator, would be inconsequential. It would be near zero as well.

Q Does it make a difference in doing the injection that ultrasound – Well, let me ask you this: Is ultrasound, would you agree, is a two-dimensional plane?

[p. 246] A It's a two-dimensional field, but it's an exquisite technology. I mean, everything is very clear. You're looking at a field produced in an array that lines up coming from the sonogram monitor in this direction to the sides, and the sonogram, the ultrasound head is approximately that big. The transducer you would use is approximately that big.

Q If you could, just for the record, the dimensions don't – won't appear in the court reporter's notes unless you give us dimensions that you showed with your hands.

A Oh, okay. I don't know the exact dimensions, but the dimensions approximately of the average sonogram transducer head, the one I use in my office, for example, would be approximately two – two to three centimeters wide by approximately eight to 10 centimeters in length.

Q And can you move what you describe the transducer head, can you move that around on the body?

A Yes.

Q So that you can increase the field by just moving the location on the body?

A You get a very clear picture of what's going on inside of a pregnant uterus by – as close as you can get to an actual three dimensional looking into the womb by moving the transducer around on the field, that's correct.

Q Now, as far as the questions I would ask you, the type of substances that could be injected into a fetus while it's [p. 247] in the uterus to cause fetal demise, what's your understanding of the generally-accepted substances that can be injected for that purpose?

A Are you –

Q And to create abortions, or do – associated with abortions.

A Are you speaking of actually into the fetal body cavity or into the fluid or both?

Q Any chemical agent to cause fetal demise?

A Well, the standard techniques that are injected where amniotic fluid is first removed and then replaced with a substance for what is considered an installation

technique of abortion would be a hypertonic saline solution which has been generally discarded. It's not used very much anymore. A hypertonic urea solution which may or may not be used with a Prostaglandin solution as well. Those are the main ones, and then if you are talking about injecting the actual fetal heart, Digoxin has been used in the past but is not considered the sine qua non of that procedure anymore. My understanding from speaking with several colleagues is that potassium chloride is the agent of choice at this time.

Q And as far as – Just from your knowledge, would there be contraindications, reasons that would you would cause a risk of harm to, the mother by injecting those substances into the fetus or the fetal area to cause fetal demise?

[p. 248] A Well, I would say that nothing is 100%, but in the hands of a skilled operator, you shouldn't run but a very small risk of any maternal complications from that.

Q If you had a mother who had a seizure, preexisting seizure disorder, would that be a reason why you would not do the injection to cause fetal demise?

A Not particularly, no.

Q Well, would it be a reason or not?

A No.

Q How about if the mother had preexisting heart disease?

A I would say that in a preexisting heart disease, if you are instilling something into the fetal heart to stop it

such as potassium chloride, followed by whatever procedure that you're going to use to remove the fetus from the uterus, the potassium chloride, in and of itself, would not be a contraindication due to her heart disease.

Q Now, the fetus is within the area known as the placenta, correct?

A No.

Q Tell us where it's at.

A The fetus is in the amniotic sac.

Q Okay.

A The placenta is attached to one aspect of the amniotic sac.

Q The question I would have is, if you attempted to inject [p. 249] a substance into the fetal heart to cause fetal demise, and you didn't actually hit the heart but you hit surrounding area and just injected the substance, what's your knowledge and understanding of the substances that you would use to inject it with that would essentially get into the mother's bloodstream? How can that happen, I guess is what I'm asking.

A Well, Digoxin, for example, if you injected it and you missed the baby and injected it into the umbilical cord or one of the, you know, placental vessels or something like that, it could potentially get into the mother. Whether that would cause – It would be a very rare state of conditions that that would happen in the hands of a skilled operator. It would be very rare that the amount of the drug that would be used would cause significant damage to the mother if that happened. I mean, my

assessment of that would be the potential for harming the mother, given a very limited set of circumstances, is pretty low. You would not want to ever inject potassium chloride into a mother because if you did that to any substantial degree, you might stop her heart, but again, in the hands of someone that is a skilled professional, the risk is miniscule.

Q How do you define a skilled professional or a skilled operator?

A Someone who has training in this field of performing [p. 250] these particular events and has performed them on a number of occasions.

Q Now, as a general proposition in performing an abortion, is there any medical advantage to the mother in injecting the fetus or killing the fetus in some manner by an injection prior to removing the fetus from the uterus?

A Medically speaking, I don't believe that there is any advantage to that. I mean, of killing the baby first, then removing it. I mean, in terms of advantageous to the mother, no.

THE COURT: Counsel, just so you understand, I understand that answer to say that there is no medical justification or reason for killing the fetus in utero for purposes of the maternal health.

MR. SMITH: You understood it correct, Your Honor. Frankly, the reason I asked the question is so the Court understands that I am attempting to present a witness that, in my view, is not biased.

THE COURT: I appreciate that, but I want you to understand what I understood the answer to be.

MR. SMITH: Okay.

THE COURT: Okay.

BY MR. SMITH:

Q Now, as far as medical procedures that would be common to abortions, would it be common performing an abortion that [p. 251] the physician would need to dilate the cervix?

A Yes.

Q And could you explain in performing abortions just what the problems would be presented in dilating the cervix over the gestational ranges increase and how those problems can be addressed?

A The ease of doing a procedure, whether it's an elective or a medically-indicated abortion, you have to dilate up the cervix. The cervix is usually – has a – the external os is usually relatively small, less than half of a centimeter at the most, and sometimes is small, in a girl that's never delivered a baby, as a pinhole. It can be very, very small, and so generally, what occurs, depending on the size of the pregnant uterus and the gestational age is that in, say, a very early pregnancy, anywhere from six to eight weeks or even as high as 10 weeks, you could just dilate the cervix with the use of dilators, surgical dilators Pratt and Hegar dilators.

Q Are these instruments?

A These are surgical instruments, right. They are blunt-ended, progressively larger dilators where you start out with a very small, thin instrument, and you progress your way up to the size where you would need

to have it to be able to insert a suction cannula to do a suction procedure of the uterus. Like I said, up through, say, 10 weeks gestation, [p. 252] you really shouldn't need much more than dilators. If you start getting up into 13 weeks, 14 weeks, 17-week procedures, you're going to need the use of what are called most people use laminaria which are dehydrated seaweed stems.

Q Let me ask you the questions as far as when you describe up to the certain point, 10 weeks or whatever weeks you used after that, you wouldn't use the surgical dilators. Is that correct?

A Well, there are surgical dilators that go up to very large sizes, and – but if you are going to be dilating the cervix over a very quick period of time, most people would say that once – and it's up to the person doing the procedure and it's up to what their experience is and what their training is – but if I were going to be doing a procedure, say, on a 10-week miscarriage where the baby has died or the fetus has died, I would use the dilators myself. If I had a 12- or 13-week, I would probably put laminaria stems in the mother.

Q Why would you do one thing at 12 and 13 and something else earlier?

A The metal dilators that are used for dilating the cervix, in most instances, most people would agree that if you are forcibly dilating the cervix more than about 1.2 centimeters, it would stand to give some substantial harm to the cervix if you are doing that quickly over the period of a [p. 253] few minutes versus allowing a patient to have laminaria placed in their cervix that are small and

then soak in the fluid from around the surrounding tissues, and they dilate slowly over a period of hours.

Q What's the risk created by the harm to the cervix?

A Well, the point that we're always concerned about is whether you may be inducing a cervical incompetence.

Q What is that?

A That is where the cervix integrity and strength has been damaged by some type of injury.

Q Okay. And what is the cervical integrity and strength needed for? Why do you want to try to avoid harming it?

A So that you would be able to retain, keep inside the uterus a pregnancy in the future.

Q In other words, the cervical integrity is necessary to keep the fetus in the uterus, is that accurate?

A Correct. Correct. Otherwise, you could sustain a miscarriage just simply because the cervix opened early, and in that case, you would have to undergo a more complicated procedure to sew the cervix called which is called cervical cerclage, you do those between, you need to, but if you don't need to, you certainly don't because you're introducing lots of other potential risk.

Q The laminaria, you indicated, if I recall you correctly, you would use that starting at 12 weeks, 13?

[p. 254] A I would, if a situation occurred where I was, say, a patient came in that was 12 weeks or beyond is when I would use laminaria, and I would use the

smallest number and the smallest laminaria I could to allow the cervix to open up to the extent where I could get that 12- or 13- or 14-week fetus out.

Q Can you just tell us what a laminaria is and how you use it and how it is effective?

A Laminaria are seaweed, I believe, Japanese seaweed, and they dehydrate them into little rods that are about four or five centimeters long, and they are attached to a string. What you do is you place them into a cervix, into the cervical external os and up into the cervix because you want to dilate the internal os as well, so that they are, once you put them in, the laminaria, you can see the end of the laminaria and the string in the vagina, but for the most part, the laminaria is inside the cervix, and what happens is, they are very dehydrated, and just like with any particular principle of where there is one dry area or dryer area or hyperosmolar area where there is – It draws fluid into it from the surrounding tissues, just a naturally-occurring event, and when that seaweed has been dehydrated, soaks up the fluid from the tissues around it, it becomes much larger, several times larger, and if you put in – If you are able to put in two or three small laminaria and they [p. 255] expand over a period of, say, eight to 12 hours, then you can place larger laminaria in, and then they would expand up to the point where you have the cervix opened to the extent where you can do the procedure you need to do.

Q And does the laminaria allow one to expand the cervix gradually over a period of time other than forcibly over a short period?

A Yes.

Q And what you ultimately are trying to do with the laminaria is just expand the cervix in order to get the fetus out, correct?

A Correct.

Q As far as medical risks to the mother and medical advantages, I'm going to ask you, is there a medical advantage to the mother in abortion by partially delivering the fetus alive, killing the fetus, and then completing the delivery?

A No.

Q Are there risks to the mother by a physician who would deliberately partially deliver a fetus alive, kill the fetus, and then complete the delivery?

A No.

Q My question was the risk to the mother from – by a physician who would partially deliver the fetus alive, then kill the fetus.

[p. 256] A Oh, the risk. I'm sorry.

Q Yeah. The first question was the advantage and the risk.

A I'm sorry. Would you ask that question again? I must have missed it.

Q Okay. Are there risks to the mother by the physician who is doing an abortion with deliberately deliver the fetus alive partially into the vagina, kill the fetus, and then complete the delivery?

A Okay. Okay. I'm sorry. Yeah, the risk to the mother are that, at that particular point, the fetal head is

within the uterus, and performing any procedure at that point, whether you would crush the fetal skull or whether you would do any kind of instrumentation, if you – such as piercing the back of the fetal neck at the junction of the skull and pursuing a suctioning event through the skull, you are still introducing into the vagina a sharp instrument, and if the head is still inside the cervix and inside the uterus, and that is still inside, then you are doing that blindly. In order to get in there, you are passing a sharp instrument –

Q Let me stop you. Why would you be doing it blindly if you have got an ultrasound?

A Well, because once you get that low into the pelvis, you are bumping up against the pubic bone, and your vision is going to be much different than if you are up on the abdomen [p. 257] doing an ultrasound. My understanding is, with this particular issue, is that at this point, the ultrasound is not of use, and what is is just manually feeling the area you're going to and placing your instrument in there.

Q What's the risk of doing the procedure in that manner or doing that blindly?

A Well, if you, anytime that you place any kind of sharp instruments into the vagina, you are going to be passing the anterior wall of the vagina, passing underneath the pubic bone on the anterior wall of the vagina is the urethra. On the other side of the wall of the anterior vagina is the bladder. Again, you're talking about also passing by the cervix and the cervix is supplied by vessels, and –

Q You mean blood vessels?

A Blood vessels carrying blood, and then into the cervix or the uterus.

Q Is the risk that you would perforate any of those tissues that you described?

A There is always a risk of that whenever you are placing a sharp instrument in there.

Q You believe the risk would be higher even for a skilled operator as a blind procedure?

A I believe that any kind of blind procedure, there is a risk regardless of how skilled you are.

Q Would you believe it's greater than if you are using a [p. 258] sharp instrument where you can see what you're doing with an ultrasound?

A Yes.

Q Is there a risk of harm to the mother, either removing a dead fetus from the uterus or – Well, strike that. Is there a risk to the mother in performing an abortion or when you're doing a miscarriage and removing a dead fetus from the uterus? Is there a risk to the mother posed by the fetal tissue in the uterus remaining in the uterus?

A If you allow fetal tissue to remain in the uterus, there is always a potential for bacteria from the vagina to get into the uterus, either at that time or later, that would cause an infection in the uterus. That is the largest risk.

Q And how does the physician deal with that risk?

A You would finish the procedure that you're doing. If you believe there is placenta left or fetal tissue of any kind left, you would follow up whatever procedure you've just done by a suctioning or sharp curettage of the inside of the uterus to be certain that there would be no fetal tissue left.

Q And in the hands of a physician who knows what he's doing, if he does perform the procedure to finish it, as you described, is there still a medical risk to the woman?

A It would be very very small, if any.

Q Are you aware of any general accepted medical principle [p. 259] or any medical literature or knowledge that the brain contents of a fetus would be toxic to the mother if they got into the mother's blood system?

A You don't want any type of fetal tissue, regardless of whether it's amniotic fluid, amniotic fluid embolus or fetal amnion tissue or placenta or fetal brain or fetal lung or anything else, you don't want that to get into the mother's circulation, but the brain is no more toxic than anything else.

Q Than the placenta or any of the other fetal parts?

A Right.

Q Now, as far as how you actually perform your medical procedures when you would remove a dead fetus in a miscarriage situation, where do you do those procedures?

A At the hospital in the operating room.

Q And is there any particular reason why?

A In my particular practice, and I believe most people's opinion, anytime that you are doing a procedure for removing a fetus from the uterus, there is a potential for complications to arise which you would need to be within a hospital setting so you could attack that situation very quickly and resolve it, mostly, especially in terms of a larger pregnancy past 12 or 13 weeks, the chance for maternal hemorrhage.

Q You could, if you wanted to, do the procedures in your [p. 260] clinic?

A You could.

Q You choose not to?

A Right.

Q And the reason is, you think it's safer in the hospital?

A Right.

Q And at least in your experience as a physician, you have had to deal with a situation where others have attempted abortions in the clinics, and then you had to deal with the complications when the mother was taken to the hospital, correct?

A Correct.

Q Do you understand what is meant by the term peer review?

A Yes.

Q Can you tell us what that means?

A Peer review is a situation where, within the hospital staff setting, colleagues, fellow physicians, are always scrutinizing the activities of another physician. This comes into a meaningful situation where there have been actions by a physician or complications arising from procedures by a physician that are out of the realm of the ordinary, and they are then marked by other personnel that something unusual happened or something unusual was done, and this is addressed by the particular physician's department within the hospital, by his colleagues.

[p. 261] Q Would it involve a process in which there would have to be justification for procedures then?

A Correct.

Q Now, what peer review is there in your clinic setting?

A If you are a solo practitioner in your clinic setting, there are no peers.

Q Are you a solo practitioner?

A Yes.

Q Do you have peer review in your clinic?

A No.

Q As far as the actual methods that you use in removing a dead fetus from the uterus in a miscarriage situation, what medical procedures do you use?

A From when a fetus or from when a pregnancy is recognizable and requires a D & C done, for example.

Q And if you could explain the terminology rather than abbreviations.

A I'm sorry. Let's say in a situation where there is observable fetal tissue greater than, say, six, seven weeks gestation in size, if a miscarriage or what's called a missed abortion occurs where the fetus is dead and remains in the mother, does not miscarry spontaneously, from that point on up through 13 weeks, I would do what's called a dilation and curettage, or a D & C is another term for it, a short term, where I would dilate the cervix, again, as gently as possible [p. 262] in the operating room, to the point where the appropriate sized suction curette could be placed into the uterus and perform as gentle a procedure of evacuating the uterus of the fetal tissue at that point as possible.

Q What's the mechanism for evacuating?

A I'm sorry. The mechanism?

Q What mechanism for evacuation of the fetal tissue?

A You would use, for the majority of the fetal tissue, a suction curette which is – Well, a suction curette is a typical sizes – different sizes, and they range from small to large. The typically, you're going to be looking at a curette that is seven or eight millimeters up to 12 millimeters at the most. Most of the time when I'm doing a suction procedure of the uterus where a curette is introduced, it's approximately the size of the end of this pen or a little bit larger which is usually about an eight or a 10 millimeter curette widthwise.

Q I interrupted you. If you could just go ahead and continue to describe the medical procedures.

A Well, I dilate the cervix to the point where I can put in the appropriate size curette, and then you put the curette in with no suction at that time, and then you close – The suction is on, but it's open to the air on the outside, so it's suctioning air out, and then you close that, and it creates a closed suction environment inside the uterus and [p. 263] very effectively sucks the fetal and placental tissue in. In the particular instance of a missed abortion where the tissue has not come out on its own, it's more difficult than, say if a patient were in the middle of an incomplete abortion where some of the fetal tissue has already come out, and that's an easier procedure than having to go in and take it out. Usually there is some trailing placenta or fetal membrane tissue that is left following a suction procedure, and so it's usually advantageous to clear the remains, go around the uterus one time with a sharp curette as gently as possible to make sure that the tissue is completely out, and that's the procedure.

Q Okay. Then in more advanced stages of gestation, what procedures would you use?

A After 13 weeks, you would perform what's called a dilation and evacuation, D & E for short, for the removal of the fetus where you would basically dismember the fetus. Most of the time when you're dealing with a fetus that has already died, and it has been usually two or three weeks between visits where the patient has felt or you've observed the fetal heartbeat, either with a Doppler or an ultrasound. The patient comes back in, you can't find the heartbeat. It has usually been the period of about four weeks, and the patient is not to the point yet where they would notice fetal movement, and so the baby

has been dead for a few weeks by [p. 264] the time you see it. When that takes place, the fetus in many circumstances is very apt to start basically falling apart when you're trying to remove it from the uterus, and what you would do at that point is make sure that you have every part of the fetus. You reassemble the fetus on a surgical what's called a Mayo stand or a surgical stand on your operating room or table and make sure that you have all the fetal body parts and a placenta.

Q Now, is there at some point in the gestational age when you would be removing a dead fetus that you don't use the dilation and evacuation procedure?

A In my particular practice, if a fetus is larger than 16 weeks, and some people go 18 weeks, other people who in the field go as far as 20 weeks.

Q And would any of those judgment calls, would it be within generally-accepted medical standards?

A Right, but you're talking about a 16-week or larger fetus. Would – You would consider doing what's called an induction procedure on the patient where basically you put in laminaria again, the same particular procedure I described before, and then instead of proceeding to a procedure where you would remove the baby with a suction and sharp curettage or dismembering the fetus, you would put the patient into labor either with intramuscular Prostin or a Prostin vaginal suppository or high dose Pitocin intravenously.

[p. 265] Q And then just go ahead and tell us what happens.

A Basically, you put the patient, you shorten the time that the patient would be in labor by dilating the cervix up to a particular point with the laminaria. You take those laminaria out, and usually if you've gotten the cervix up to the appropriate size, the fetus, it doesn't require much in the way of a long protracted labor to get that fetus to deliver because they are usually still pretty small, and you would do just a medical induction of labor with the agents I described before, whichever you chose to use.

Q When you start the process, are you able to predict or determine when the actual delivery would occur?

A Predict? You can't predict exactly when it's going to occur, no.

Q And that was what I was trying tc get was the time frame that you would be talking about once you would introduce the Prostaglandin from the time you would reasonably expect a delivery or an expulsion of the fetus?

A You can't predict it with any certainty, no.

Q Is there a range of time you would reasonably expect?

A I've seen women who actually went into labor just from laminaria being placed and delivered a baby either at home or on the way to the hospital all the way to it taking eight to 12 hours has been my experience, so it can happen either before you intend for it to or later.

[p. 266] Q Now, as far as the induction procedures you've described, is that procedure contraindicated if the

mother has heart disease, diabetes, renal disease or prior C-section and C-section meaning prior cesarean section?

A If – if there were any – In most of those – Would you please repeat the particular conditions?

Q Let's take them one-by-one.

A Okay.

Q Would the induction procedure be contraindicated or something you would not – that's not recommended that you use in a situation of a mother who has had heart disease?

A It depends on what the heart disease is.

Q And can you explain that?

A Well, it depends on how severe the heart disease is, and you – In any kind of heart disease, a labor process is likely to increase the cardiac output and the work the heart has to do, so if you have any question of whether you're going to potentially harm the mother by putting her into labor, then again, in the hands of a skilled operator, there are people that do D & E's past where I do them, and if I had a baby that was that large with a mother with virtually any of the complications you just described, I would be passing them on to a high risk obstetrician in a formal high risk center.

Q Would you be doing that in the clinic setting?

[p. 267] A No.

Q Now, as far as gestational age, how do you determine the gestational age of a fetus?

A Well, the gestational age is determined, the first way that you do it is by looking when the lady's last menstrual period started. That's considered the gestational age.

Q How do you know when that was?

A Just by her history.

Q What she tells you?

A She tells you.

Q Okay. Go ahead.

A A significant amount of time, what she tells you and what you see sonographically by the ultrasound are two different things. Then you've got a conflict of what your gestational criteria are, but with very early ultrasound, such as in my office, I use a vaginal probe ultrasound is one of the transducers I have on my machine which you can do a crown to rump link on a baby very early on.

Q Crown to rump link. Are you referring –

A The head to the butt.

Q Of the baby?

A The head to the butt, that's right.

Q Okay. Go ahead.

A You would do the crown to rump link on the baby which will tell you virtually within days of how far along the baby [p. 268] is. If that does not match up whatsoever with the last menstrual period, then you take that as your criteria, or if the woman is the least bit

uncertain, then that is your best criteria because you have got it within days. Past 13 weeks, it gets a little bit more difficult. Different factors come into play. The size of the baby is, even ultrasoundwise, is not as precise after 13 weeks, and if you get past 16 weeks, you're going to be dealing with plus or minus one to two weeks, and you're way off, you can be, from that point you can be three to four weeks, you know, distance around the particular gestational age is a factor there, so reliably, in order to tell a – how far along a lady is, the best indicator of how far along a baby would be would be to having an early, prior to 13-week vaginal probe ultrasound early in the pregnancy.

Q And if you don't have that, would it be accurate, the way you would make the determination, as relying upon what the mother tells you on her last menstrual period and the ultrasound?

A Right. You just try to get your best, you add up what you've get and get your best guess after that.

Q And your best guess or estimate can be off plus or minus how much?

A Two weeks.

Q Is there a point in time of gestational age in which it [p. 269] is generally recognized in the medical profession that fetuses are not viable, if you know?

A Are not viable?

Q Are not viable.

A Under a certain age?

Q Yes?

A Viability is a concept which has changed significantly since I have been in medical school. It is generally accepted that a fetus is considered viable by most experts at 22 to 23 weeks at this point.

Q And of those that are considered viable at 22 to 23 weeks, that doesn't mean all of them, correct?

A Correct.

Q It just means at 22 to 23 weeks, you do have a percent that you would expect would be viable?

A Correct, and, you know, the earlier, the less chance that they would have to be viable and the later, say, you know, 29 weeks, the greater chance to be viable.

Q And that assumes the determination of the weeks of the gestational age is accurate, correct?

A Correct. You can have vast differences that I have personally seen where a fetus measured much smaller, and the computer on the ultrasound predicted that the baby's age was much smaller or much earlier than it actually was. In my training at Parkland, there was a baby that was born alive [p. 270] that appeared to be very early, and back then, in the late 80's, '88, '87, '88, 25, 26 weeks was the edge of viability at that point, and this baby appeared so small that it couldn't have possibly been any further than about 22 or 23 weeks, and what was done was, the baby was born alive, but because it was so small, there was no chance it could survive, so it was left over on a stand in the delivery room basically to die because it couldn't live at that size. When the baby was still over there on its own moving around and

breathing 30 minutes later, they determined to call the intensive care unit and get the baby over there, and as it turned out, that particular baby was a victim of what is called intrauterine growth retardation, and due to what was thought to be maternal hypertensive disease, was much smaller than it should have been, and the maternal stress had caused the baby to mature much quicker even though it was much smaller, and I know for a fact, I don't know what ultimately happened to that baby, what its intact survival was or whether it survived long term, but I know for a fact that baby was alive for several weeks, so size and what a sonogram can tell you is not perfect.

THE COURT: Let me inquire of plaintiff's counsel, plaintiff makes no contention that plaintiff has the right to do post-viability – Post-viability abortions are not an issue as asserted by the plaintiff, is that true?

[p. 271] MR. HELLER: Your Honor, plaintiffs – Well, I don't think this case involves the issue, but certainly, plaintiff intends to abide by the Nebraska statute which prohibits the performance of post-viability abortions unless necessary to protect the woman's life and health, and I think plaintiff's testimony was, he doesn't do abortions after viability.

THE COURT: Well, what I'm asking you is, there is – Plaintiff does not contend that he does post-viability abortions?

MR. HELLER: That's correct.

THE COURT: And that this statute somehow interferes with his ability to do post-viability abortions.

MR. HELLER: That's correct, Your Honor.

THE COURT: All right. Thank you.

MR. SMITH: Just so the Court understands, the latter portion of the testimony on viability, my purpose for introducing that was really directed at impeachment of Dr. Carhart's qualifications and expertise. That was the purpose for it. I do have a couple of questions, and I will conclude with Dr. Riegel.

BY MR. SMITH:

Q Dr. Riegel, as far as the concept of peer review at the hospitals where you have privileges, does peer review go on there?

[p. 272] A Yes.

Q At all of them?

A Yes.

MR. SMITH: Nothing further.

THE COURT: Counsel?

CROSS-EXAMINATION

BY MS. WALZ:

Q Yes, I have, excuse me, just a couple of questions, Dr. Riegel. I believe when you were speaking before, you talked about how after about 13 weeks gestational age, you use the D & E procedure?

A Um-hm.

Q At 16 weeks and higher, you go to the induction procedure?

A That is what I do. There are overlapping methods of doing these particular things, these particular procedures. Some physicians would like, some high risk physicians, people that are trained and have done a four-year residency in OB-GYN, then two or three more years in nothing but high risk obstetrics would feel more comfortable still performing D & E's or evacuations after the point where I feel comfortable doing it. In my particular setting, the mode of practice among the physicians that I work with is about 16 to 18 weeks, you would perform an induction.

Q And why is it that you and these particular people that [p. 273] you practice with decide that at that point you prefer not to do a D & E anymore?

A We believe that the D & E might be somewhat riskier at that point than the induction would.

Q How is it riskier?

A The D & E is riskier than an induction because you are placing instruments into the uterus, and there is potential for harm to the mother, more so than if you were performing an induction where you just, the baby would deliver, and then if the absolute worst case scenario, you might have to do a curettage of the uterus to get placental fragments out or something like that.

Q But part of the induction procedure doesn't normally include the introduction of these instruments into the uterus, isn't that correct?

A Correct.

MS. WALZ: Thank you. I have nothing further.

THE COURT: All right. It's now about 10:48. May I suggest we take our mid morning break of about 15 minutes? Does the doctor have airport, is he going to get to the airport at 2:00?

MR. SMITH: He needs to be out of here at 2:00.

THE COURT: We can do that, can't we?

MR. HELLER: I believe we can, Your Honor.

THE COURT: Well, we will. Fifteen minutes.

[p. 274] (Recess from 10:47 to one 11:04 a.m.; all parties present)

THE COURT: Have the defendants concluded their examination of the [sic] this witness?

MR. SMITH: Yes, Your Honor.

MS. WALZ: Yes, Your Honor.

THE COURT: You may inquire.

CROSS-EXAMINATION

BY MR. HELLER:

Q Thank you, Your Honor. Dr. Riegel, is this the first time you've testified in court?

A Yes.

Q Have you provided affidavits in cases or sworn written testimony in court before?

A I've never been in court before.

Q You indicated in your testimony that you don't perform abortions, is that right?

A Correct.

Q And what is the reason that you don't perform abortions?

A I choose not to perform abortions due to moral objections.

Q Does your – does your practice include provision of birth control, prescription birth control?

A Yes.

Q You also testified a little bit about your background and experience. Have you had any academic appointments?

* * *

[p. 276] Q You weren't involved with any dilation and evacuation abortions for medical indications as you prescribed them, is that right?

A No, not myself.

Q Did you observe any at the Parkland Hospital?

A I have seen some going on. I didn't directly go in and stand behind them and watch them, no.

Q You have seen them going on. You were aware they were going on?

A Right.

Q What stages of pregnancy were the D & E's performed at Parkland Hospital?

A To tell you the truth, my experience there is so limited, I can't even tell you. Generally, if I saw a procedure going on, from my moral, particular personal

moral [p. 277] view, and I chose, just other than the ones that I had to take over out front, the inductions going on, I chose not to be associated with them.

* * *

[p. 279] Q You gave some testimony about injections. I think you talked about amniocentesis?

A Um-hm.

Q That you performed, is that right?

A I have performed them in the past, yes.

Q On how many occasions have you performed amniocentesis?

A Several. I have no idea of knowing how many.

Q Do you think it's a hundred?

A Probably somewhere between 50 and a hundred.

Q What's the purpose of that procedure when you do it?

A Amniocentesis is performed early at 13 to 18 weeks of gestation for genetic diagnoses.

[p. 280] Q So is it because the woman requests it?

A Correct.

Q And it's an elective procedure?

A Correct.

Q You certainly wouldn't ever do amniocentesis if the woman didn't want it, would you?

A No.

Q When you do amniocentesis, you describe some of the risks that could be present, like risk of infection?

A Yes.

Q Do you inform them of that risk?

A Yes.

Q Do you inform them of any other risks during amniocentesis?

A Yes, there is always a risk of, even though it's small, of bleeding during the procedure. You could inadvertently nick an umbilical cord vessel or a placental vessel, or you might hit a sinusoid going through the uterine wall which could start bleeding, and then, of course, you give them the overall, what was touted as the overall miscarriage rate related to amniocentesis. In teaching institutions at the time that I was involved with these was about one in 200.

Q In the amniocentesis procedure you perform, am I correct that you are withdrawing some fluid?

A Correct.

[p. 281] Q And are you withdrawing it from inside the fetus or the fluid around the fetus?

A The amniotic sac.

Q That's around the fetus?

A Correct.

Q You're not injecting anything into the woman?

A No.

Q How – Let's take the example of 16 weeks. How large is the fetus at 16 weeks?

A How large?

Q I realize that's a little unclear. If you were to measure the fetus from one end to the other, how would – What would you estimate the size to be?

A Well, I happened to see a 17-week fetus a few weeks ago. The lady miscarried and the fetus was from head to foot probably – I didn't measure it – but probably 10, 8, 9, 10 inches.

Q At 17 weeks?

A This one, it was about this big, the one that I just saw a few weeks ago.

Q Are you aware that the State of Nebraska publishes a booklet that says that at 17 to 18 weeks, the fetus is five-and-a-half to six-and-a-quarter inches in length?

A Well, again, these are – I'm looking at a fetus in a pan that I did not measure, okay. I don't measure foot to – [p. 282] There is no reason to measure and know a way to measure foot to head measurements of a fetus. Even when you're doing ultrasound, there is no measure. I was telling you those are approximations but I'm just looking at what I saw, and I'm guesstimating at what that is. I don't know what the State of Nebraska published, no.

Q Well, I may show you this in a minute regarding some other questions. Do you know from your training or experience what the size of the length of a fetus is at 16 weeks in centimeters?

A That is not – That is something that is available to be studied if you desire to. It is never something that I have ever been tested on or note that nobody has ever asked me about, and so therefore, I don't have all of the inches measured at particular gestational ages in my lexicon of knowledge at this time.

Q I understand that. I'm asking for information that ordinarily you have access to a book or chart maybe to look something up?

A Correct.

Q What I'm trying to get a sense of is, let's say at 16 weeks, do you know what the size of the fetal heart is?

A I can't tell you exactly, no. I know what it looks like on an ultrasound machine.

Q Well, I want to give – get an idea of how large of an [p. 283] object, if you were injecting into the fetal heart, how large of an object.

A It's small. I can't tell you exactly how large it is. Usually when you're looking through an ultrasound machine, you magnify it several times.

Q Do you have any idea from your training if it's larger than one centimeter in size at 16 weeks?

A I can't tell you at all exactly how big it is in size, and anything that I would say, I would be guessing, so I'm not going to say anything.

Q You would agree, though, that the size of the fetal heart is much smaller at 16 weeks than the size of the amniotic sac, wouldn't you?

A That's obvious, yeah.

Q Might be 50 times smaller?

A Right.

Q So it might be significantly easier to administer or to get the point of a needle into the amniotic sac than it would to get it into the fetal heart?

A It would be obviously easier to get it into the sac than the fetal heart.

* * *

[p. 285] Q You gave some testimony saying that, talking about the risk in an injection of perforating bowel, and you said it was a virtually zero, and I want to ask you what the basis is for your opinion that it's virtually zero risk?

A In anytime that I have ever looked into the – through a sonogram, and again, many, many of these, plus discussing this with other experts in the field, high risk obstetricians, there has never been an incidence where there was bowel in front of the uterus where you were attempting to do an amniocentesis. I have never seen that.

Q So you are talking about anecdotal reports, your own experience and those of colleagues?

A Right.

Q How many cases do you think you've heard about?

A Where the bowel has been punctured?

Q No, no. You said you hadn't heard any of those. I'm just trying to get a sense of how many. Was it 50 or a hundred or a thousand?

A If you are talking about extended, hundreds.

Q And so out of some hundreds, you haven't heard of a [p. 286] single case of perforated bowel?

A Correct.

Q But you don't know of a statistical study that says the risk is one in a thousand?

A No, I do not.

Q And you said the risk of injecting the mother was inconsequential?

A It's very small as well.

Q Is that again based on sort of anecdotal information you have rather than statistical study that was done of how often that occurs?

A Correct. I'm talking about my own experience and what I've heard, and I have numerous friends and colleagues that are high risk obstetricians.

Q So it would be one in a thousand?

A I don't know what the number is. It's going to be very, very small.

Q I'm trying to get a sense of when you say very small, do you mean more like one in a thousand or one in a million?

A Probably more in line of one in a thousand, but I don't know what the number is.

Q You said you had spoken, I think you said you had spoken to some colleagues who said that potassium chloride would be the agent of choice in trying to induce fetal demise. Do you recall that testimony?

[p. 287] A Yes. I recently spoke with a colleague who is at a major university medical center, high risk obstetrician, who said that.

Q Is that someone who does that injection of potassium chloride into a fetal heart or fetus?

A I don't know whether he personally does or he does not. I know that some of the methods of terminations he has taken part in in the past, I have no idea whether he's actually done KCL injections, potassium chloride injections in the heart before.

Q Do you know what stage of pregnancy KCL injections are used?

A I know they are usually considered in the late term. Late mid trimester abortions is my understanding.

Q What do you base that on?

A Just from what I've read.

Q Where have you read that?

A Limit of actually probably the ACOG technical bulletin that was put out in '87. I think I read it possibly there.

I'm not 100% sure where I have read it. I know I have read it I have read so many things, I can't tell you exactly where, but my understanding is that that is done later.

Either the AGOG technical bulletin or some other publication or textbook.

Q What's the risk to the woman if the potassium chloride [p. 288] is in that maybe one in a thousand or, say, maybe one in 10,000 chance that the injection goes into the woman instead of the fetus?

A I don't – Whenever you have potassium chloride, I'm not sure exactly the amount that's injected into the fetus, because I have never taken part in that. That information is not something that comes across my desk ever. I don't know the exact amount, I don't know the exact amount that that what would cause a fetus's heart to stop would do to a mother. You would obviously never want to inject potassium chloride into mother regardless of the amount?

Q Why is that?

A Because potassium chloride can stop the heart. That's why you're injecting it into the fetus, but I have no idea how much a fetal dose would do to a grown woman. I don't know.

Q Do you know if potassium chloride can pass, say, through the umbilical cord to the woman?

A I would say that the chance of that occurring due to the fact that as soon as you inject potassium chloride into the fetus's heart, it stops, is very, very small.

Q I was asking a different question. Suppose by accident that the physician injects not into the heart but into the umbilical cord. Could go into that the woman's circulation pretty readily?

[p. 289] A I don't know whether potassium chloride – I don't know is the answer to that. I don't know.

Q Is there some mechanism that, in general, prevents substances that are in the fetal blood system from passing to the woman's blood system?

A Some substances do pass, some substances do not pass. Digoxin, you can give to a mother to change the rate of a baby's heart, so it does pass. You do not give the mother potassium chloride, and therefore, I've never come into contact with that, and I don't know the answer to it.

Q Would you agree that whether a substance passes depends on the size of the molecule?

A Molecule, correct.

Q Isn't potassium chloride a pretty small molecule compared to Digoxin?

A I'm not certain what the molecular size of this is. Again this is not information that even a high risk obstetrician is going to have at his fingertips.

Q I understand, but I mean, for example, potassium chloride, you would agree is two atoms potassium and chloride?

A Right. It's small.

Q It's small. I mean, I just wanted to see if it's pretty small. Is Digoxin a small molecule, do you have any idea?

A I have no idea exactly what the size of Digoxin is. I [p. 290] know it crosses the placenta.

Q You talked about the risk to the cervix of cervical incompetence from dilation. Is that risk the same when you use metal rods and when you use laminaria?

A Nobody knows 100% what the mechanisms for cervical incompetence is, and the reason for that is that some women who have never had anything done to their cervix have cervical incompetence, and other women that have had several abortions apparently don't, so we're not sure exactly what it is.What I'm addressing is the risk factors involved, and it is generally thought among obstetricians that if you quickly dilate up the cervix with metal rods, it stands more of a chance of damaging the cervix than if you slowly dilate them with laminaria.

Q So using laminaria is generally believed to be safer than the metal rods dilation?

A Generally, but again, that is just basically based on common sense principles, and there is no documentation of that that I'm aware of.

Q And – Nor is there any documentation, for example, that the insertion of laminaria causes cervical incompetence. There has been no study that shows that, as you indicated, that the use of laminaria for women who have had laminaria inserted, she is more likely to experience cervical incompetence?

[p. 291] A Anytime you put anything into a cervix, it is a risk factor for possible future incompetence. That is not to say that a lady who has had three elective abortions using nothing but Hegar dilators, followed by another elective abortion using laminaria, is going to

have a future cervical incompetence. You cannot predict that.

Q Because there could be other factors probably?

A Right. There's probably factors that we're unaware of at this time.

Q You testified that if a fetus were delivered intact or removed intact feet first, I think is the procedure you were talking about, that there would be a risk to the woman because in crushing the skull or piercing the neck, you would be inserting a sharp instrument into the vagina, is that right, or into the cervix?

A There is – In doing what I have read is this D & X or intact dilation and extraction procedure where the fetus is delivered up to the point of the head still being inside the uterus slash cervix area, that is not something that with the fetus being in the vagina is immediately visible to you, and so part of what you're going to be doing is going to be inserting sharp instruments into an area where you are feeling versus being able to see, and my point was that whether you are doing a D & E dilation and evacuation procedure where you are dismembering a fetus with sharp [p. 292] instruments inside the cervix, or whether you are doing a D & X procedure where you are cutting a hole, ostensibly, inside the cervix, you're still passing sharp instruments through the vagina where you could damage the urethra, the bladder, the vaginal wall, the cervix, into the uterus.

Q I understand. Do you insert sharp instruments more when you dismember the fetus?

A Usually, it has been my experience that the fetuses that I have been involved with usually dismember on their own.

Q Well, yeah, but those are dead fetuses?

A Correct.

Q Would live fetuses –

A My understanding is that live fetuses can often break apart too because their tissues are very soft.

Q What about a fetus at 19 weeks? Would the fetus readily break apart if it was alive at that stage?

A I'm not certain of the answer to that, but my feeling would be probably not.

Q So you might have to do more surgical insertion of surgical instruments into the uterus to dismember that fetus, is that right?

A That would make sense.

Q Than you would if you just had to insert once to crush the skull. Doesn't that make sense also?

A Well, my understanding of that procedure is that you do [p. 293] – You pass more than once into the uterus, but you do go back in to do the skull.

Q What I'm trying to get a sense of is, isn't it true that in a later abortion where the fetus is alive, let's say after between 16 and 19 weeks where it's less likely to come apart.

Q Um-hm.

A That in dismembering the fetus and removing it in pieces, you are more likely, you are going to be inserting sharp instruments on more occasions than if you remove it all in one piece. Doesn't that just make sense?

A That's true, but in my experience, and the experience of the people that are friends of mine that have done that, in the hands of a skilled operator, the difference, the incidence of complications from that are relatively small.

Q How many times have you removed a dead fetus at 19 weeks?

A Nineteen weeks.

Q Yeah.

A Removed it with a D & E procedure? I don't do them at 19 weeks.

Q Okay. So you said you wouldn't do a D & E procedure after about 16 weeks?

A Sixteen to 18. It just depends it depends if a lady is gestational age of 18 weeks but the fetus measures 16 weeks, then I would do it.

[p. 294] Q Well, how many times have you done that at 16 weeks? How many times have you done a D & E?

A Several. I don't know the exact number.

Q Less than 10?

A Probably more than 10, less than a hundred. I don't know the exact number. Probably more like if I was guessing, it would probably be 10 to 20 times.

Q Over the course of your career?

A Um-hm. It doesn't come up very often.

Q Well, I understand. I'm just trying to get a sense of how often it comes up because that is going to affect your assessment of what the risk factor is. If you do it 10 or 20 times and nothing goes wrong, you may feel as if the risks are very low, but if you were to do it more times, more likely you could see that risk that only happens once in a hundred times, wouldn't you agree?

A I know from the numbers that are presented in the literature that the risk is low.

Q I want to show you Exhibit 7.

A What's that? Exhibit 7. Oh, okay.

Q Yeah. Have you seen that document before?

A Yes, I have.

Q Could you turn to page 8 of this document?

A Okay.

Q And the last paragraph on this page discusses the intact [p. 295] dilation and extraction procedure. Do you see that paragraph?

A Yes.

Q And the second-to-last sentence says, "This procedure may minimize trauma to the woman's uterus, cervix, and other vital organs." Do you see that statement?

A Correct.

Q Do you disagree with that statement?

A I believe that "may" is the operative word there, and I believe that depending on who the person that would be doing it would – The experience would be much different among different people.

Q And that reflects the fact that the safety of the given procedure depends on how often the physician may have done that before, what experience they have in doing the procedure, is that right?

A That's correct, but this particular procedure is not a recognized procedure in any medical text or database that I can find. This is the first document that I've ever seen that even refers to it in print aside from the newspaper. This procedure, in my four years at Parkland, was never even discussed, talked about, intimated, brought up among the best obstetricians in this country.

Q Well, now, you hadn't heard of this procedure before you read this document?

[p. 296] A No, I've heard about it in the press. The way I was informed about this procedure is in the press, in the lay press, and then I started hearing about it in the medical press and in any medical textbook or database of any kind, aside from this is the first time I have ever seen this in a medical – in anything related to medical procedures, and it's because the lay press and the people that perform this procedure coined the term intact dilation and extraction.

Q Isn't that what it is? You dilate and extract, intact, the fetus. Isn't that what the procedure is?

A Yes, but that is not a recognized medical procedure is my point.

Q Until this document?

A Until they refer to it in this document. Again, unless that procedure is being taught at major medical institutions and is subject to peer review, it is not a medically-accepted procedure.

Q That's your definition of what a medically-accepted procedure is?

A My definition of a medically-accepted procedure is that it's something that is performed under the scrutiny of other physicians and is an accepted practice amongst physicians.

Q Well, but abortion isn't an accepted practice at all to you, is it?

A That doesn't have any bearing on what is accepted among [p. 297] other physicians. That is a personal belief of mine.

Q Well –

A And it also does not affect the way that I look at abortion.

Q Would you agree with the statement that from the American College of Obstreticians and Gynecologists this is the definition, dilation and evacuation is a generic term that encompasses cervical dilation followed by evacuation of the products of conception. Do you agree with that definition of dilation and evacuation?

A Yes.

Q Is dilation and evacuation an accepted medical procedure?

A Yes, but this isn't –

Q Well, let me –

A This is a totally different thing. Find this in a medical textbook.

Q What makes in [sic] totally different?

A Find it in a medical textbook.

Q What makes this totally different?

A What makes it totally different is that amongst accredited physicians and experts in the field, it does not exist. That's what makes it different versus every other type of D & E, every other type of induction procedure for abortion, everything. This does not exist.

[p. 298] Q What is the basis for your opinion that it doesn't exist among accredited physicians or doctors?

A Williams Obstetrics is published where I was trained. It's considered one of the Bibles of obstetrics. It's not there. It's not in Gabbe's Textbook of Obstetrics. It's not in the prolog you study for the boards. It's not in any textbook because I have looked for it.

Q Have you looked for a procedure called craniotomy?

A Yes.

Q Is that in Williams Obstetrics?

A Yes.

Q Would you describe that procedure?

A It's – A craniotomy means that you poke a hole into the cranium.

Q Isn't there a procedure described in Williams Obstetrics whereby a fetus is removed, the after-coming head is too large to fit through a cervix?

A That can exist in a number of different forms.

Q Isn't that what this procedure is?

A No.

Q What's the difference?

A The difference is that in most cases of what you're talking about an enlarged after-coming head such as in a condition of hydrocephaly or hydranencephaly, you insert a tiny spinal needle through the abdominal wall to remove the [p. 299] excess fluid and deliver the baby. That's called cephalocentesis.

Q Through the abdominal wall?

A Through the mother's abdominal wall and into the uterus because it's a large head. That's called cephalocentesis.

Q Into the fetus's head?

A Yeah.

Q I'm just trying to get a sense of what is it about the definition of dilation and evacuation as I read it to you that indicates a physician is supposed to dismember the fetus?

A That is the accepted way that a dilation and evacuation and the only way I've ever heard of a dilation and evacuation being discussed or written about until this came into the lay press, and again, this is not an accepted mode of dilation and evacuation, and, in fact, I can quote the American College of Obstetricians & Gynecologists say they can, they say that they cannot imagine a particular time when this particular procedure is the preferred mode of delivery. That's paraphrasing what they said in their committee opinion or whatever that little thing was where this was the only mode that was available or the preferred mode something to that effect.

Q I'm going to show you a document that hasn't been marked. I think this may be the one you're referring to.

[p. 300] A It is. It's right here on the second page.

THE COURT: Counsel, I believe that has been marked, and I believe it's Exhibit 19.

MR. HELLER: Well, we had marked –

THE COURT: It has not been offered.

MR. HELLER: We had marked something else as Exhibit 19. This, if we want to mark it, I don't think we will. I just wanted to give it to the witness.

THE COURT: Go ahead.

BY MR. HELLER:

Q That's the document you're referring to?

A Um-hm, yes, it is.

Q What is that document, that paragraph on the second page say about this procedure?

A It says the terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by American College of OB-GYN could identify no circumstances under which this procedure as defined above would be the only option to save the life or to preserve the health of the woman.

Q Would you continue, please?

A An intact D & X may be the best or appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor in consultation with a [p. 301] patient, based on the woman's particular circumstances, can make this decision. Potential exists that legislation prohibiting specific medical practices such as the intact D & X may outlaw techniques that are critical to the lives and health of American women and the intervention of legislative bodies and the medical decision making is inappropriate, ill advised, and dangerous.

Q I take it you disagree with parts of that paragraph?

A The American College of Obstetrics and Gynecology is an organization that puts out certain opinions. Those opinions are influenced by the people who have made their way to the top of the American College of OB-GYN, and I can tell you without question that this particular procedure amongst the Fellows of a [sic] the

American College of OB-GYN and board certified OB-GYN doctors who are not of the American College of OB-GYN disagree with that statement.

Q Did you take a vote of the college?

A I didn't take a vote of the college. I'm talking about my experience in Dallas, Texas, with people who mostly are pro-choice.

Q I'm [sic] just want to be clear. You didn't poll the American College of Obstetricians and Gynecologists?

A No, I never said I did. I'm talking about my experience in Dallas, Texas. -

Q With people you know?

[p. 302] A And with the American College of OB-GYN. This is not the opinion of the rank and file American College of OB-GYN member.

Q Just based on your speculation or guess?

A Based on my experience which is all I can testify to.

Q Do you use intramuscular injections of Prostaglandin?

A Yes, I have.

Q Has that been peer reviewed?

A Peer reviewed?

Q That procedure, doing intramuscular injections of Prostaglandin?

A In my experience, peer review takes place at the facility that you're working at, and in formal peer review,

both at Parkland Hospital and at the hospitals that I now have privileges at, it is used. I'm not certain I understand your question.

Q I'm talking about, are there peer reviewed studies of intramuscular Prostaglandin?

A I believe the only – I think I understand what you're asking. The only one, to my knowledge, that I think is the intravaginal route. However, there are other – Just because something has not been approved in use for a particular procedure does not negate its use in that particular procedure, and this is a well documented, well described use of Prostaglandin to induce labor.

[p. 303] Q Is it reported in Williams Obstetrics?

A I'm not certain whether it is or not.

Q If it wouldn't be, that would make it nonacceptable medical procedure?

A It's an accepted medical procedure because at one of the best training institutions of the country, it's done all the time. In my definition of an accepted medical procedure, the D & X is not accepted medical procedure.

Q If you knew that, let's say you knew, and I'm not saying this is the case, but suppose you found out that intact dilation and evacuation was being used at San Francisco General Hospital, would that change your opinion?

A Unless intact D & X was being used around the country all the time, I don't think it would change my opinion on it.

Q How many hospitals would have to be using it in order to change your opinion?

A I can – I don't know an answer to that. I don't think it's ever going to be done in hospitals.

Q Why is that?

A Because the people, it is a distasteful procedure that is never medically indicated to save the life of the mother and certainly not to save the life of the fetus, and that's what occurs in hospitals for the most part.

Q Have you ever had a woman – I'm sorry. You indicated that maybe 10 to 20 times you induced, essentially induced [p. 304] delivery of a dead fetus after 16 weeks, is that right?

A That's an estimate, yes.

Q And that would be 10 to 20 times since – Well, would it be since graduating from medical school?

A Since 1988.

Q So maybe one to two per year?

A About that.

Q Have any of those women ever said, I would rather not undergo an induction. I would rather do some other method?

A No.

Q If you could look at the Exhibit 7 that I handed you before and turn to page 7 of that document, I think you testified that, in essence, that induction after about 16 to 18 weeks is the method that should be used for doing abortions?

A I did not say it was a method that should be used. I said that where I practiced, that is what most people do, and that's what I do.

Q You would agree that the chart on page 7 of this document appears to indicate that no more than about 9.1% of abortions after 16 weeks are done by induction, wouldn't you?

A That's abortions.

Q Well, yeah. That's my question, about abortions.

A These are induced abortions, not indicated deliveries of demised fetuses.

[p. 305] Q I understand that. I'm asking the question about this chart.

A That's what the chart says, correct. I mean, I'm sure that's what the numbers are.

Q Is there a reason that you would be doing inductions more often with a dead fetus than to do an abortion of a live fetus?

A Since I don't practice abortion, I don't know if I can answer that question, but since, either way, you're going to end up with a dead fetus, I don't think it really matters much in my brain.

* * *

[p. 306] Q In an induction procedure where you are using Prostaglandin, now I'm talking not about abortion but delivery of a dead fetus.

A Um-hm.

Q What are the side effects of the Prostaglandin injection?

[p. 307] A You can have nausea, vomiting, diarrhea, fever.

Q In your experience, has that happened from time-to-time?

A Yes.

Q And during the induction procedure, are women able to carry on their ordinary daily activities?

A Ordinary daily activities?

Q Well, going from place-to-place, moving around, doing housework, going to their job if they have one. Are they able to do all those things during the induction procedure?

A No. They are in the hospital getting injections with Prostin every three hours.

Q And you indicated that in your experience, the patient is in labor about eight to 12 hours at the most, is that right?

A That's a guesstimate. That has been my experience. It's short, relatively short.

Q Could it be 36 hours in some cases?

A I'm sure it would be 36 hours in some cases. That hasn't been my experience.

Q I'm talking about what you have read in literature or ACOG discussions.

A It probably could go that far. I don't remember what the outlier is for that.

• • •

[p. 312] Q In terms of the procedures you do involving or have done involving dead fetuses, removal of a dead fetus?

A Um-hm.

Q Is there more bleeding that occurs in that procedure than would occur in the instance of a live fetus?

A Possibly.

Q I mean, do you think there is?

A In all likelihood, that's accurate.

Q And there is also more – I'm going to use this word more degeneration of the fetus in the sense it may have been dead for a few weeks?

A A few weeks, yes.

Q That may explain why it comes apart more easily?

A Correct.

Q Do you agree that if you dismember a fetus and remove it, there is more likelihood, let's say at 16 or 17 weeks, that there will be some bones, sharp bones that may perforate the woman's uterus?

A I cannot imagine the cartilaginous bone, the very thin bone of a 16-week baby perforating a uterus. I'm sure that somewhere it has occurred at some point or it

wouldn't even be brought up, but the chances of that occurring is – has to be extremely small.

[p. 313] Q You talked about the risk of infection from the injection from any amniocentesis-type injection. What was the risk of infection quoted by you?

A I was quoted recently by my colleagues, high risk physician, that the number was one in a thousand of infection-related events at the time of a genetic amniocentesis.

Q Assuming that that is the same for injection of Digoxin, that would be a risk on top of the preexisting risks of doing abortion, isn't that right? It's an added risk?

A If I – if I have a risk of one in a thousand of it occurring, that's really a small risk. I guess if you want –

Q It's a risk you would disclose to a patient?

A Yeah.

Q There are some risks that are probably so small you don't even disclose them because it's so completely remote, you don't – you don't disclose it at all, isn't that right?

A I disclose everything that I think is physically possible during any case, any operative procedure that I do. I mean, there are things that are unforeseen. A tile could fall out of the ceiling and hit the lady on the head. I don't disclose that to her.

Q Of course not, but I suppose the purpose of disclosing it is so she, the patient, can weigh the risks and

decide [p. 314] whether she wants to obtain that procedure?

A That's why we do informed consent.

* * *

BY MR. HELLER:

Q I think you may have said this in answer to one of my questions. I want to be clear. If a woman is pregnant and she is taking Digoxin, does that pass to the fetus?

A I'm sure that in that, we treat, we cardiovert babies that have a tachycardia with Digoxin, and it gets to the baby that way. I'm sure that some quantity of the drug does get to the baby.

Q So would it stand to reason the same would be true if you injected the fetus with Digoxin within the heart or another part of the fetus, some part of that might pass to the woman?

A I think the risk of that [sic] very, very small. Considering the reason you're doing it is to stop the heart, if you stop the heart, then the flow back and forth between the mother and baby should stop to the greatest extent, and therefore, [p. 315] the risk is extremely small.

Q Again, when you say extremely small, you're not putting a number on that. You're just saying maybe one in a thousand, would that be fair?

A I have no idea what it is, but it's got to be real small.

Q Have you reviewed the Nebraska law that's involved in this case?

A I read it, yes.

Q Do you have an opinion about what types of procedures it prohibits?

A I would – Can I get a copy of that?

Q Yeah. Let me see if I –

A I remember what it says substantially, but I can't quote it.

Q I'm going to open it to page 4 which may be the best place to start with because it contains the definition.

A Okay. Let's see here. Okay.

Q First, let me ask you, do you see the term substantial portion in that definition?

A Yes.

Q How would you define substantial portion?

A To me, that would mean that some percentage, probably over 50% of the size probably would be what that would mean. It's a vague term, but it's, you know, I would imagine that a [p. 316] substantial portion, if you are eating a substantial portion of a pie, I would say you ate half or more of the pie. That's probably what it means to me.

Q Some people might think it means 30% of the pie?

A Right. I have a large appetite.

Q Now, again, looking at that status.

A Um-hm.

Q Do you think that could cover a procedure where an abortion procedure – I'm obviously talking about here with a live fetus and the doctor has dilated the cervix and reaches into the cervix, grabs onto a leg and removes the leg while the fetus is still alive and then finishes the abortion.

A I don't think that's what, in my interpretation of this, which is what you're asking, I don't think that's what it means, no.

Q Tell me what you do think it means.

A I think that it means that in the procedure that I think is at issue here, a substantial part of the baby, meaning that a good part, 50%, 75% has been delivered, and then the life of the baby is specifically ended at that point before the head comes out so that it cannot – Its heart is not beating when the head is delivered; therefore, it's dead is what it means to me.

Q The word head, for example, doesn't even appear in the statute, isn't that right? There is no mention of a head in [p. 317] there or any other part, is there?

A It just says a substantial partial delivery – let's see – for purposes of the this provision, partial delivery of a child means killing them or child means delivery into the vagina a living or unborn child or a substantial portion thereafter. To me, it says either the whole child, nearly the whole child or a substantial portion thereof is what it says.

Q So either the whole fetus, child, or a substantial portion of it is delivered through the vagina, and then the

fetus is killed and the procedure is completed. Is that your understanding of it?

A Um-hm. My understanding is that it says substantial portion, and I guess, as you mentioned, it might mean different things to different people, but it says a substantial portion. And I know what I interpret that as. It seems pretty obvious to me what they are saying.

Q Let me ask it this way: If you were observing a physician doing an abortion?

A Okay.

Q And I understand that is distasteful to you.

A That's all right.

Q And you observed on an ultrasound camera a live fetal heartbeat, so you knew the fetus was alive at the beginning of the procedure.

[p. 318] A Okay.

Q Then you observed the physician reach in with forceps, grab onto the leg of the fetus, pull on the leg, and the leg was disjoined and removed?

A Um-hm.

Q Through the vagina.

A Um-hm.

Q Has the doctor removed a substantial portion of the living, unborn child? Do you consider the leg a substantial portion?

A I probably would not, given my interpretation of this, no.

Q What if the doctor reaches in and grabs onto something and half the fetus comes out, and then the doctor completes the procedure. Would that be substantial portion?

A I would say half or more of the baby, or three-quarters, half to three-quarters is what I would say. I read this in context of what I understand is at issue here, and to me, substantial portion means half to three-quarters of a baby, which to me would mean up to or about the chest or the head.

Q And where do you – where Have you obtained your understanding of what this law is about?

A I'm reading this, and in context of what I know is at issue here, that's the way I interpret it, and I've read – I mean, I've read numerous places about this particular [p. 319] procedure. I mean lay press, *Wall Street Journal*, I've read all kinds of places. I can't tell you exactly where I read it, but in the lay press and then obviously it has been in the OB-GYN press here for the last few months.

* * *

[p. 322] Q At about 14 weeks, is the fetus, if it's alive, is it mobile within the amniotic sac?

A Is it moving?

Q Yeah.

A It's moving. It can move. It can stay still too. They are still sometimes, and they move sometimes.

Q Would the mobility of it affect your ability, one's ability to inject a substance into the heart of the fetus?

A I guess it could if the fetus was real active.

Q And the amniotic sac as a whole, is that mobile?

A Mobile?

Q Does it move around?

A The amniotic sac?

Q Yeah. I'm trying to compare when you give an amniocentesis, when you do amniocentesis for genetic testing, you're taking fluid out of the amniotic sac. I'm trying to [p. 323] get a sense, does that move around?

A Well, I think – No, but what you are looking for is unoccupied pockets within the fetal sac, the amniotic sac, and if you are dealing with a baby that's moving, obviously, the unoccupied pockets are going to change.

* * *

Closing arguments

[p. 361] THE COURT: Let's reduce this to something less than an abstraction, maybe to something more. If a woman came in here and said, look, I want the D & X because I believe the D & X poses less risk to me. Assume that first.

MR. GRASZ: Um-hm.

THE COURT: Then assume that the evidence was undisputed that the D & X as opposed to an intact D & E or a D & X was 1% safer than a dismemberment D & E and 1% safer than an infusion, I think is the word, or a hysterotomy or hysterectomy. Are you telling me the

State of Nebraska can require that woman to undergo a greater risk of personal demise?

MR. GRASZ: I believe that the test as set forth by the U. S. Supreme Court in *Casey* as to whether it's an undue burden, they have never said that, you know, there's only one in a thousand chance procedure of risk cannot or must be used if there is another one where it's only one in 900.

THE COURT: But I'm talking about the one woman who comes in here to court and says, Judge, I can prove to you that the procedure that Dr. Carhart does is 1% safer than any other procedure, and assume that she proves that.

MR. GRASZ: Under her specific circumstances.

THE COURT: Under her specific circumstances, and assume that she does that. Are you telling me the State of Nebraska can require her, as a matter of law, to undergo that [p. 362] 1% additional risk because it – Well, are you telling me that it can do that?

MR. GRASZ: Well, first of all, I think we are talking about a constitutional challenge as applied.

THE COURT: I understand.

MR. GRASZ: And under those circumstances.

THE COURT: All right.

MR. GRASZ: In general, I think the answer has to be, yes, the Supreme Court has never said that the State's interests must be completely set aside and disregarded because of some marginal or slight increase in

risk to the woman, especially when we are talking her about children who are near viability. The State's interest, even under *Roe v. Wade*, the Court said that the State's interest increases until it is compelling, so it's a very, very strong compelling or near compelling interest that the State has, whereas, in the example you have given, the woman's interest is only very marginal and slight by comparison.

THE COURT: What if it's 5%, safer?

MR. GRASZ: Well, at some point, a court would have to determine that's an undue burden, too much risk.

THE COURT: And you think this applies previability? I mean, do you think this analysis you're suggesting to me applies previability before time that the child could survive or an extended period of time if [p. 363] delivered?

MR. GRASZ: Well, I think the question assumes that the State has not presented evidence showing that partial-birth abortion method is not safer than alternatives that are available. We're relying on our testimony, not a hypothetical to defend the statute.

THE COURT: Well, I understand, and judges ask hypotheticals to try to isolate in their own mind the arguments that counsel are making. I gave you that hypothetical so that you could respond to me hypothetically because it helps me understand your argument.

MR. GRASZ: I would certainly – It would certainly be our position that the undue burden test of *Casey* does not allow for a scenario where any marginal increase

in risk to the mother automatically outweighs, per se, the State's interest.

THE COURT: Previability.

MR. GRASZ: Yes.

THE COURT: Tell me why you get this. I mean, where do you find this law?

MR. GRASZ: Even previability, the State has very strong interests approaching compelling, especially where we are talking about late term abortions.

THE COURT: I understand the State's interest is important, but where do you get the idea that the State's [p. 364] interest previability is sufficiently important to require a woman to face a 1% greater likelihood of death. Where do you derive that analysis from any of the cases?

MR. GRASZ: Well, the Supreme Court in *Casey* said very clearly not all burdens are undue burdens.

THE COURT: Death is undue, isn't it?

MR. GRASZ: Certainly.

THE COURT: And isn't a 1% greater chance of death an undue burden to that woman?

MR. GRASZ: It could be in certain circumstances.

THE COURT: Well, she's dead. It's undue.

MR. GRASZ: There is no testimony presented here, Your Honor, that would establish even a 1% greater risk of death.

THE COURT: The AMA studies that you stipulated into evidence show. Am I wrong?

MR. GRASZ: That's out of 100,000, not out of 1,000, so we are talking a very, very, very small number.

THE COURT: Well, for the person who dies, that's a big number, right?

MR. GRASZ: It's 1.4 out of 100,000.

THE COURT: But for the person who dies, that is a large number, and that's why I'm pushing you on that, on this. I mean, that's –

MR. GRASZ: For the child that dies, it's a 100% [p. 365] number, and the State has a very strong interest in protecting unborn life, and the United States Supreme Court has recognized that.

THE COURT: But it's never been said to be the same previability, has it?

MR. GRASZ: We are talking about partially-born children for one thing. The Supreme Court has never said there is any right to kill partially-born children in any circumstance.

THE COURT: Okay. Okay. I understand that. I understand that argument, but you don't think any of the Supreme Court's jurisprudence applies here because you think this is entirely sui generis, is that right?

MR. GRASZ: Yes, Your Honor.

* * *

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(31)

No. 99-830

Supreme Court, U.S.
FILED
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In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

JOINT APPENDIX VOLUME II, PAGES 241 TO 481

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

TRANSCRIPT OF TRIAL PROCEEDINGS,
BEFORE THE HONORABLE RICHARD G. KOPF,
UNITED STATES DISTRICT JUDGE

* * *

[p. 3] THE COURT: Good morning. We are on the record in Carhart vs. Stenberg. Would counsel enter their appearance, please?

MR. HELLER: Simon Heller, Center For Reproductive Law and Policy for the plaintiff.

MR. HUG: Jerry M. Hug, Omaha, Nebraska, for the plaintiff.

MR. SMITH: James D. Smith, Assistant Attorney General, for the defendant Stenberg, Dunning, and Charles Andrews.

THE COURT: Good morning, counsel. You were good enough to visit with me in chambers. We have set a briefing schedule, and we'll enter an order as we agreed in chambers on the briefing schedule. My understanding is that we will not have formal oral argument, but you'll submit the matter on the briefs. However, I may have some questions after the end of the trial, and if so, I will address them to you at that time orally.

I do want, as I indicated to counsel for the plaintiff, I do want to know what the plaintiff's position is in terms of whether or not this is as an applied challenge or a facial challenge or both. I have some uncertainty about whether the plaintiff is – whether a single plaintiff can

mount a dual as applied challenge and a facial challenge, so we need to know that clearly in the briefs.

[p. 4] I think that is all we need to put on the record at this time. Are counsel ready to proceed?

MR. SMITH: Yes. There is one other matter on one exhibit, Your Honor, that was not received by the pretrial order.

THE COURT: Well, yes. I was just talking now about preliminary matters. My understanding is that all of the exhibits that are attached to the pretrial order that have been received pursuant to the pretrial order are now offered and received, is that right?

MR. SMITH: That's correct, and I think the report would probably need some clarification as to what Exhibit 33 is since the record doesn't reflect that yet.

THE COURT: I'm not talking about Exhibit 33 yet, counsel.

MR. SMITH: Okay.

THE COURT: But all of the 1 through 32 are received in evidence, is that right?

MR. HELLER: Yes, Your Honor.

MR. SMITH: That's correct.

THE COURT: Now, the parties, I understand, additionally stipulate that Exhibit 33 may be received in evidence. Does the clerk have Exhibit 33?

COURTROOM DEPUTY: Yes.

THE COURT: All right. Give it to me, please. I [p. 5] hold in my hand counsel Exhibit 33 which on its

first page purports to be a memorandum to co-sponsors of LB23 from Senator David Maurstad dated April 10, 1997, preliminary information on partial-birth abortion, and then there are various pages attached to that memorandum. All right. That's what I understand that Exhibit 33 is.

MR. SMITH: Yes. Exhibit 33 actually is, in its entirety, comes from the internal legislative file of Senator David Maurstad, comes from his file for LB23, and there are two colored pages that are part of Exhibit 33, and what those colored pages denote, three separate documents. In other words, they are Exhibit 33.

THE COURT: Oh. I see.

MR. SMITH: After the first colored page is one document, after the colored page it's another document, after the next colored page would be the third document, all three of which documents in Exhibit 33 came from Senator Maurstad's legislative file.

THE COURT: So really there are three documents. The first is a memorandum and attachment I just indicated to co-sponsors of LB23 from Senator David Maurstad. The next is – there follows a red page followed by another memorandum judiciary committee memorandum to KAB from JSP dated April 11, 1997, re: constitutional argument re: LB23, partial-birth abortion, followed by another red piece of paper and another [p. 6] judiciary committee memorandum to KAB to JSP dated April 11, 1997, re: committee amendment to LB23.

MR. SMITH: That's correct.

THE COURT: Now, are the parties in agreement that that document maybe received in evidence?

MR. HELLER: Yes, Your Honor.

MR. SMITH: Yes, Your Honor.

THE COURT: All right. It is received in evidence. Okay. I take it then all of the paper evidence is now in, is that right?

MR. HELLER: That's correct, Your Honor.

MR. SMITH: That's correct.

THE COURT: All right. The plaintiff may proceed.

MR. HELLER: Thank you, Your Honor. Like to call Phillip Stubblefield.

PHILLIP STUBBLEFIELD,
PLAINTIFF'S WITNESS, SWORN

THE COURT: You may inquire.

DIRECT EXAMINATION

BY MR. HELLER:

Q Thank you, Your Honor. Good morning. Would you please tell me, what is your profession?

A I'm a physician.

Q Where did you receive your medical degree?

A Harvard Medical School.

Q What year was that?

[p. 7] A 1966.

Q Did you, after medical school, complete an internship?

A Yes, I did.

Q And where was that internship?

A University of Michigan, Ann Arbor.

Q After your internship, did you do any further medical training?

A Yes, I did. I did a three-year residency in obstetrics and gynecology at Boston Hospital for Women.

Q Have you received any board certification?

A Yes, in obstetrics and gynecology.

Q Are you licensed to practice medicine in any states?

A Yes, in Massachusetts.

Q What is your current employment as a physician?

A I'm a professor and chairman of the department of obstetrics and gynecology at Boston University School of Medicine and director of obstetrics and gynecology for the Boston Medical Center.

Q What is distinction between the Boston Medical Center and Boston University?

A The hospital is a private, nonprofit corporation distinct from the university. It's not owned by the university.

Q Is the hospital a teaching hospital?

A Yes, it is.

[p. 8] Q Could you just explain to the Court what a teaching hospital means?

A It's a hospital that accepts either residents in training in specialties or medical students or both. Most teaching hospitals have both. We have medical students from our university rotating through my service. At anytime, we have 25, 26 medical students. And in addition, in all of the major disciplines, we have training programs where physicians who have completed medical school do their post-graduate training as necessary to be certified in a particular discipline.

Q How many residents do you have in your department?

A Currently I have 19.

Q Prior to your position at Boston University and Boston Medical Center, what position did you hold?

A My previous position was chief of obstetrics and gynecology at the Maine Medical Center in Portland, Maine. I also held a professorship at the University of Vermont at the same time.

Q Can you describe the Maine Medical Center? What is that?

A Maine Medical Center is the largest hospital in the state of Maine, a primary and secondary hospital for the community around it and tertiary hospital for the state, providing pretty much all medical services that exist. We

had [p. 9] independent residencies. My service at that time, we had 12 residents in OBGYN and rotating medical students from the University of Vermont.

Q Can you describe for me your current medical practice?

A Yes. I spend most of my time being an administrator and teacher, doing a little investigation from time-to-time, but I do still practice clinically. I spend half a day a week in our faculty group, private practice, and half a day a week in our resident clinic in the hospital with my residents seeing patients. I cover the labor floor for deliveries once or twice a month for a 24-hour period and also operate half a day or a day a week depending on what needs to be done.

Q You mentioned doing some teaching currently. What does your teaching role consist of?

A Oh, it's varied. Some of it is actual classroom instruction, lectures, seminars for medical students. More of it in terms of time is spent seeing patients with the residents, helping them to take care of their patients, operating with them, teaching them how to operate, doing deliveries with them, teaching them how to manage in labor and delivery.

Q When did you receive your board certification in obstetrics and gynecology?

A In 1975.

Q Have you, since 1975, been in an active practice [p. 10] throughout that period of time?

A Yes, I have.

Q Do you perform abortions, or have you performed abortions as part of your medical practice?

A Yes.

Q In your current practice, do you perform abortion procedures yourself?

A Yes.

Q Do you also supervise?

A Yes.

Q Could you give me an estimate of currently, on an annual basis, how many abortions you supervise in your current position approximately?

A Well, the service for which I am responsible provides 1,500, 2,000 abortions a year. My direct involvement is to spend a half a day probably twice a month with the residents where I will do two or three abortions myself. The others I will be coaching residents.

Q That's part of their training?

A Yes.

Q In what type of setting are the abortions you supervise and perform done; that is, are they inpatient in a hospital, or are they own [sic] an outpatient basis?

A They are both.

Q Going back to your position at Maine Medical Center, did [p. 11] you also perform abortions there?

A Yes, I did.

Q Can you tell the Court approximately how many abortions you did on an annual basis or how many abortions you supervised on an annual basis there?

A My involvement in Maine was that one-half day every week I supervised the residents. We performed six, eight, 10 procedures, and then in addition, in my private practice, I offered D & E abortion through about 22-and-a-half weeks of pregnancy, primarily for women with illness or with fetal malformations.

Q In your current position at Boston Medical Center, do you have a cutoff after which you won't do abortions?

A The hospital policy limits us to 20 weeks as a cutoff.

Q Prior to your position in Maine Medical Center, what position did you hold?

A My immediately-previous position was chief of obstetrics and gynecology for the Mount Auburn Hospital in Cambridge, Massachusetts.

Q And were there abortions performed at that hospital?

A Yes.

Q Prior to your position at Maine Medical Center, were you doing teaching?

A Yes.

Q Where were you teaching?

[p. 12] A I was teaching at Maine Medical Center, but at Mount Auburn Hospital while we didn't have

residents, we did have medical students rotating from Harvard Medical School.

Q Have you held any teaching positions at Harvard Medical School?

A Yes. When I left there to go to Maine, I was in the – clinical associate professor.

Q In your position. I'm sorry. Was that –

A Yes, I am finished.

Q In your position while you were at Harvard, what period of time were you at Harvard Medical School?

A I have to stop and think about that. I completed my residency in '73, and I maintained – I had a Harvard appointment probably as an instructor or an assistant professor which I maintained over the years until I left Boston, I believe it was '88, to go to Maine, so '73 through '88.

MR. HELLER: May I approach the witness, Your Honor.

THE COURT: You may.

BY MR. HELLER:

Q Dr. Stubblefield, I would like to show you what's been received in evidence as Exhibit 29 and just ask you to identify that.

A Yes, that's my curriculum vitae.

[p. 13] Q Would you take a moment to look over, and is it current as of today, do you know?

A Actually, it's a few months behind. I have a few more publications that aren't on this version.

Q But it's current as to your current position?

A Yes. Yes.

Q During your time at Harvard from 1973 up to 1988, I believe you said, did your medical practice include abortions throughout that period as well?

A Yes, it did.

Q And did that include both performing and supervision of abortions?

A Yes, it did.

Q Do you currently teach abortions? I think you indicated that you trained and teach abortions?

A Yes, I do.

Q What techniques of abortion do you teach?

A Vacuum curettage, first trimester; D & E procedure early mid trimester; and my service also provides a labor induction method that we employ generally from 17 to 20 weeks.

Q At Maine Medical Center, did you teach those same techniques, or were there other techniques that you would teach there?

A I didn't – We really did very few of the labor induction abortions. D & E was primarily what I practiced [p. 14] and taught.

Q You indicated, I think, at Maine Medical Center abortions were offered through 22-and-a-half weeks, is that right?

A Yes.

Q For those later abortions, what techniques would you use?

A D & E, most of them were done by me, and I did a D & E technique.

Q Are you currently a member of any professional organizations?

A Several.

Q Can you tell me some of the more prominent ones that come to mind?

A The American College of Obstetricians and Gynecologists, the Association of Professors of Obstetrics and Gynecology, Counsel of the University Chairs in Obstetrics and Gynecology, Counsel on Resident Education in Obstetrics and Gynecology, National Abortion Federation.

Q Can you start with, just briefly, what is the American College of Obstetricians and Gynecologists?

A It is a professional group. To be admitted as a Fellow, you have to be board certified in obstetrics and gynecology, a separate organization and reviewed, and fill out your forms and present your credentials. It's an organization that is [p. 15] devoted to advancing the interests of our women patients through educational meetings, sessions, production of committee opinions and reports, and guidance for practice.

Q On your CV, you listed a number of published articles?

A Yes.

Q Have any – Do any of those articles focus on abortion?

A Yes.

Q Have the articles you've published on abortion been peer reviewed?

A Well, in my CV, I give two lists. The first list are the peer-reviewed articles that represent some kind of actual study that I was involved in. The second list are textbook chapters, for the most part, or journal review articles where I have reviewed the work of other people, but it doesn't represent my original contribution. Those that are published in the journals are peer reviewed. Textbook chapters are not.

Q What does it mean for an article to be peer reviewed? Do you know?

A Well, the way of operating of medical journals [sic] is that an article is submitted, and the editor will read it himself, but will typically send it to three or four people that the editor picks who were thought to be experts in this specific field. The reviewers are to read the article and give an opinion back to the editor as to whether they think the [p. 16] methodology is valid, the scientific content is valid, how well is it written, does it ring true. Of articles that are submitted to medical journals, depending on the journal, maybe five or 10% are going to be published. The others are going to be rejected,

you know, because the reviewers thought they were not worthwhile or badly done or not important.

Q Have you yourself peer reviewed proposed articles that other authors have written?

A Yes I regularly do that.

Q Dr. Stubblefield, would you describe for me the methods of abortion that are used in the first trimester of pregnancy?

A Yes. In this country, for the most part, the first trimester abortions are performed by a vacuum curettage, although in very recent years, there have been introduced techniques that involve medications that will induce abortion as well. But the vast majority are still performed by the surgical technique, fairly simple in concept. The cervix or the neck to the womb is a long, thin tube of connective tissue with muscle at its upper end. That cervical opening needs to be dilated. That can be done with metal dilators which are tapered rods. If you envision the cervix as a tunnel, one takes the dilators which start smaller than this and are tapered, not blunt, and gently inserts that through the cervical canal to stretch it. Then a larger dilator is [p. 17] used to stretch it a little more, and serially dilating, stretching the cervix until an adequate diameter is reached, and then a hollow vacuum tube is inserted into the uterine cavity and attached to a vacuum source, typically an electric pump, and the vacuum is used to evacuate the uterine content.

As I mentioned, the other first trimester methods that are used are medical methods. The famous RU 486, an

anti-progesterone used in combination with a Prostaglandin hormone, also a drug called Methotrexate can be used instead of the RU 486. Methotrexate has the advantage of being FDA approved and available in the United States. RU 486 is not. There are studies under way with these and other drugs to look for safe alternatives to the cervical procedure.

Q Thank you. I just wanted to ask a couple of questions about what you described. The cervix, can you tell the Court where the cervix is located in the woman's anatomy?

A It begins at the upper end of the vagina. Do you have a diagram?

MR. HELLER: Your Honor, may I approach?

THE COURT: Yes.

MR. HELLER: We've given to the State an anatomical diagram, I want to provide to the Court as a guide but not as an exhibit.

THE COURT: Why don't we – It's my practice to mark those. Let's mark them as a demonstrative exhibit.

[p. 18] COURTROOM DEPUTY: It will be number 34.

THE COURT: All right. Let's just mark it as Exhibit 34, anatomical drawing. Now, counsel, do you have an objection to me looking at Exhibit 34?

MR. SMITH: No, not for purposes of a demonstrative exhibit.

THE COURT: All right.

MR. HELLER: If I may hand a copy of it to the witness?

THE COURT: That will be fine. Thank you.

BY MR. HELLER:

Q Could you describe on the diagram for the Court the location of the cervix and how it –

A Well, this is two pictures. The upper one shows the upper genital tract organs of the woman and without showing the rest of the body. This is the uterus, this whole thing. The lower third or so of the uterus is the cervix or neck is what the word means. This is the corpus or body of the uterus up here. These are the fallopian tubes that convey the sperm and the egg. This is the ovary where the eggs come from, and the cervix continues with the vagina. You can see here the side walls of the vagina. This would be the cervical opening into the vagina. In this picture at the bottom shows how the organs would look in place in the woman's body with the abdominal wall here, the backbone [p. 19] there, the rectum pictured back here, and then this is the vagina and the uterus in situ, and the bladder, and then intestine lying above it.

Q Am I correct in saying that the cervix sort of separates the uterus from the vagina in a sense?

A In some sense, yes. The cervix is the lower third of the uterus.

Q So at the end of the cervix is where the vagina begins, is that correct?

A Correct.

Q In the first trimester procedure you described, how is the – What is it that results in termination of the pregnancy?

A With a surgical procedure, it's the introduction of the hollow tube with the vacuum so that the negative pressure is created within that hollow tube, and the pregnancy tissue is pulled out into the tube into the vacurette, it's called.

Q And I assume the fetus is removed through that tube?

A Correct.

Q Is the tube placed into the woman's uterus?

A Yes, through the cervix into the uterine cavity.

Q And how long of a tube is it?

A About that long, about 10 inches, perhaps.

Q So it extends from within the woman's uterus to outside the woman's body?

[p. 20] A Correct.

Q In that procedure where you are using suction to remove the fetus, does the fetus come out in one piece or in fragments?

A Generally in fragments. Occasionally, it can come out intact. Depends on the size of the cannula. We typically use the smallest size that will work, depending on the length of the pregnancy. For example, if the pregnancy is about eight weeks, typically we'll use a seven or

eight millimeter cannula. Every now and then, I have had the experience of thinking that the uterus is larger, perhaps, because the woman had fibroids which are smooth muscle tumors of the wall of the uterus or just that the woman has had many, many pregnancies, so the uterus has remained larger and have [sic] dilated more and perhaps used a 10 millimeter or 11 millimeter diameter cannula for a pregnancy, and the result of that is is that the fetus would sometimes come out intact.

Q Can you just define for the Court what a cannula is?

A The cannula is the hollow tube, that I referred to earlier, that's introduced into the uterus to evacuate the pregnancy.

Q In a first trimester procedure, abortion procedure, surgical procedure that you've described, is the fetus living at the beginning of the procedure?

A Yes.

[p. 21] Q How would you determine that it is living at the beginning if you wanted to?

A If you wanted to, you could use an ultrasound, depending how early the pregnancy is. You can, with transvaginal ultrasound, see the fetal heartbeat beating by five to six weeks from the last menstrual period.

Q Can fragments of the early pregnancy that come out through that cannula, can a fragment come out while the fetus is still living?

A Yes.

Q For example, could a fetal, let's say at eight weeks, are there – Does the fetus have arms and legs and hands?

A Yes.

Q Could a leg come out through the cannula and the remainder of the fetus still be in the uterus?

A Yes, it could.

Q Could the suction through the tube remove the head of the fetus first?

A Yes, it could.

Q Could it remove the contents of the head, of the fetal head?

A I don't think that would happen in the first trimester because the tissues are soft, and I think that the whole head would collapse end everything. The head would be extracted as a piece.

[p. 22] Q If there is an intact fetus which you said sometimes might come through the tube, can that be living after it's outside the woman's uterus?

A Yes, it could be. It wouldn't live for very long, but yes, it could be.

Q How long does the entire vacuum curettage procedure take from the time that the tube is inserted into the woman's uterus until the procedure is done?

A It depends somewhat on gestational age and the size of the cannula, but it's on the order of two, two to five minutes, something like that.

THE COURT: Counsel, for what it's worth, and you know probably better than I do, there is a debate about what living means. I leave it to you.

BY MR. HELLER:

Q I was just about to ask about that. Dr. Stubblefield, can you tell me, what are the criteria for determining whether a fetus is living?

A Well, as the judge just stated, that that is something of a difficult question. We have agreed-upon criteria for death of an adult or of a child, for that matter, having to do with absence of brain waves on two electroencephalograms at some interval apart as constituting brain death. In order to define it in those circumstances, there isn't any definition that I'm aware of that has been agreed upon in the [p. 23] case of a pregnancy termination. The things that you can objectively attest to, whether the heart is beating. We have an intact fetus with a heart beating, then the fetus is clearly alive.

Q At what point in pregnancy can fetal heartbeat be detected?

A About five or six weeks.

Q Can the heartbeat continue to beat after a portion of the fetus has been removed, say, in the first trimester procedure?

A Yes, it could.

Q How would you determine that it's still continuing to beat?

A Well, if you were to stop the procedure and do a transvaginal ultrasound, you could demonstrate it.

Q If I understand correctly, does that mean that a doctor could begin the suction procedure, remove a fragment of the fetus, which might be an arm or a leg, some other piece, and then do an ultrasound and see that the fetal heartbeat is still going?

A Yes, it could be done.

Q Thank you. Is there – are there – Different question. How would you make a determination that a fetus has died in the uterus, or do you make such a determination?

A Yes, you do. This is not an uncommon problem in a [p. 24] pregnancy that the patient prevents – presents for a prenatal visit, for example, and the uterus has not grown since the previous visit, measuring by height above the pubic bone, and one would obtain an ultrasound and visualize the heart and see that it's not beating, so you know the fetus has died.

Q So if – Is it always the case that you observe on the ultrasound that there is no heartbeat, does that necessarily mean the fetus is dead?

A Well, that's also not a short answer. We have, on occasion, I have seen, on occasion, in obstetric emergencies, the one that comes to mind is called the ruptio placenta where the placenta separates from the uterine wall. The fetus no longer gets any fresh oxygenated blood, and it starts to die, and we have seen situations where the patient comes in, the abruption has begun, it has moved to complete abruption as the patient was being wheeled onto the labor delivery floor from the ambulance. No heartbeat present. Cesarean section done

with a few minutes and the baby resuscitated, so it depends on the timing. If the fetus has, in fact, just died, it may be that one can resuscitate it, and we try real hard in the third trimester to do just that.

Q In the first trimester, going back to that example, if a fragment of the fetus had been removed and the heartbeat was still detectable but then stopped, is there any way to [p. 25] resuscitate that fetus?

A No.

Q Could you explain why?

A We're talking about a fetus that is about an inch long. We do not have the technology, the instruments to deal with an inch-long fetus leg torn off, now delivered.

Q Going back to, again, the vacuum curettage procedure you described, at what stage of pregnancy would that procedure be used?

A The vacuum curettage technique, as I described it, can be used up to 15 or 16 weeks. Depends on – There are alternatives. If one chooses to use the large bore vacuum cannula available up to 16 millimeters in diameter, then one can terminate at 15- to 16-week pregnancy with the cannula only. One can choose to use a somewhat smaller cannula, 12 millimeters or 14 millimeters, plus the forcep which is an instrument, sort of like a pair of pliers only a little different, that you insert through the cervix into the uterine cavity and use to grasp pieces of fetus and placenta and pull them out.

Q At what point in pregnancy might you start using forceps?

A Some physicians at 13 weeks would use the forceps and a 12 millimeter cannula. Others would use a 14 or 16 millimeter cannula and not use forceps. Beginning around 16 [p. 26] weeks, you're going to always need to use the forceps. The cannulas are not enough.

Q I want to go back a little bit over some of the terms you have used. When you refer to 13 weeks or 16 weeks, 14 weeks, can you tell the Court what definition of where you are measuring the weeks from?

A Yes. That also is not a short answer. Typically, we use menstrual weeks, referring, really, using a convention that we've agreed upon that defines pregnancy as beginning on the first day of the last menstrual period. We know that to be not true. In fact, in this sort of typical 28-day menstrual cycle ovulation is about day 14, and conception needs to occur within 12 to 24 hours after the egg is released or the egg dies. So that conception, in terms of fertilization, occurs around day 14. It's six more days before the fertilized embryo begins to implant in the wall of the uterus and you can measure the pregnancy hormone in the mother's system, so about day 20, 21 is implantation, so that, in fact, when we say a six-week pregnancy, what we are really talking about is one that is four weeks from fertilization.

Q Is there a way – How do you determine the weeks, how far along the pregnancy is? What techniques do you use to determine that?

A You ask the pregnant woman when her last normal [p. 27] menstrual period was. You count from the first day of the last period. That's the beginning of it. You can do a bimanual exam. That means two hands with two

fingers in the woman's vagina feeling abdominally. You can feel how big the uterus is. An experienced physician can tell most women, probably, give or take two or three weeks, how far along the pregnancy is from that examination, but that can be thrown off by many different things. For the last 20 or so years, we have had ultrasound, sound waves which will visualize parts of the fetus, and we can measure the size of those parts, and then we can go to charts that have been developed by observing hundreds of pregnancies, and we can use those measurements to say this fetus is the same size as the average fetus is at such-and-such weeks of pregnancy. We can measure the diameter, for example, of fetal head consistently, and we can relate that to a chart to say this fetus is 10 weeks, meaning this fetus's head size diameter is the same as the average fetus at 10 weeks.

Q Another thing you talked about was different sizes of cannulas, and you indicated that there are smaller and larger ones. Is there a reason to use a smaller or larger one for a particular woman?

A Yes. The cannula size decision is a trade off like pretty much everything else in life. If you could use a large cannula with no risk, that would be preferable because [p. 28] the evacuation of the uterus will happen more quickly with less blood loss, but in order to be able to insert the large cannula, you're going to have to dilate the cervix more. There is some risk of injuring the cervix, so our convention is to use minimal dilatation and small cannulas for early pregnancy and gradually increase the cannula size as the pregnancy progresses. One convention is to use a cannula size in millimeters in diameter that fits the menstrual weeks, so if it's an eight-week

pregnancy, eight millimeters if it's a 12-week pregnancy, 12 millimeters. In fact, you could use a 10 millimeter cannula perfectly well and evacuate a 12-week pregnancy just about as quickly, if you are experienced and know what you're doing.

Q Have you yourself used the vacuum procedure you've described?

A Yes.

Q Now, we were starting to talk about procedures after about 13, 14, 15 weeks, and you were talking about use of forceps. Have you yourself used forceps in abortion procedures?

A Yes.

Q Is a procedure involving forceps, does it have – Is it called something different or is it still called vacuum curettage?

A It is typically called a D & E, dilatation and [p. 29] evacuation.

Q Does the D & E involve any use of suction at all?

A It usually does. The D & E procedure as practiced in this country typically involves slow, gentle dilatation of the cervix using osmotic dilators rather than the steel rods and forcible dilatation I described with first trimester. The reason for doing that with the more advanced procedures is that you need more dilatation of the cervix, and you would like to accomplish that without injuring the cervix and risking later pregnancies.

Q What sort of – Can you describe for the Court what are osmotic dilators?

A The one that is used most commonly are called laminaria. They are the stem of a seaweed laminaria japonicum. They come to us as little dry sticks about five centimeters in length, two, three millimeters in diameter. When they are placed in water, they take up the water and swell to, oh, three or four times their original diameter, so if one inserts in a patient who is perhaps 16 weeks pregnant, you can insert three or four of those two-millimeter dilators one at a time into the cervical canal, just kind of pack them in gently, and over the course of a few hours, they will swell pulling water out of the cervix, and the cervix will dilate away from those laminaria, so that when you pull them out, the cervix is now considerably dilated, depending on how many [p. 30] laminaria you put in and how long you wait, and then you're then able to put instruments through the cervical canal into the uterus without pushing. You can just gently put them in. That markedly reduces the risk of perforation, of pushing an instrument through the wall of the uterus or of tearing the cervix.

Q In doing a D & E procedure, let's say, at 18 weeks, can you describe in a little bit greater detail what you would actually do with the instruments you would be using?

A Standard D & E is to have a predilated cervix with the laminaria, and then there is some variation as to what is done, but my procedure would be to insert a vacuum cannula, use that to rupture the membranes and drain the amniotic fluid, and rotate the cannula around. Sometimes that will actually begin to separate and pull out part of the placenta. Sometimes a fetal part will come out, and then switch to the forceps, pull the cannula out

and switch to the forceps, reach inside and gently grasp and turn, and then basically tear off pieces of the fetus and pull them out.

Q So you would remove a piece of the fetus as you detach it from the rest of the fetus, is that correct?

A Correct.

Q So you don't actually dismember the fetus in utero, then take the pieces, out?

A No.

[p. 31] Q Is there a reason you can't sort of dismember or disjoin the fetus into smaller pieces in the uterus and take the pieces out?

A That means you would have to introduce into the uterus something that would cut up the fetus, or else put in two forceps and try to dismember the fetus inside the uterus, which would increase considerably your chance that you're going to tear the uterus, perforate the uterus, seriously injure the woman. That is not done. What one does is reach up, grasp what you can, and pull down, and that comes apart. The fetus separates and comes out when you do that.

Q At the beginning of a D & E, is the fetus living?

A Yes.

Q And how would you determine that it's living?

A Ultrasound.

Q What would be some examples of parts of the fetus that might be removed with forceps?

A Leg, arm.

Q So could you remove a leg and have the remainder of the fetus be in a woman's uterus?

A Yes.

Q Could the remainder of the fetus still be alive?

A Yes, it could.

Q How long could, if you know, how long could a fetus in the uterus survive after a leg has been detached?

[p. 32] A I don't know.

Q Could you do the entire procedure with ultrasound observation going on?

A Yes.

Q You talked a little bit about risk of perforation or tearing. What are the major risks of doing a D & E for the woman?

A Well, there are immediate risks that have to do with trauma to the uterus and cervix, laceration or tearing of the cervix during dilating, perforation, pushing an instrument through the cervix or through the wall of the uterus with D & E procedure. Because the uterus is large and soft, it takes some skill to avoid perforation. If one is, if one perforates, one can cause extensive harm. One can badly injure the bowel or bladder or the nearby organs, cause major blood loss and clearly major injury that will have to be surgically repaired with a major surgical procedure.

Q Are there any other significant risks from a D & E other than the ones arising from perforation or laceration?

A Yes. One can have very difficult-to-control bleeding with or without a perforation. One can have what is called uterine attenuate where the uterus does not contract well and there is heavy bleeding during the procedure. There are rare, very serious complications such as amniotic fluid embolism which occurs perhaps one in 10,000 cases. Those are [p. 33] usually fatal, where tissue from the fetus enters the mother's circulation through the big venous openings inside the uterus and travel through her body to the lungs where they cause major troubles. One can also, at the end of the procedure, appreciate what's called DIC, disseminated intravascular coagulopathy where tissue from the fetus, smaller amounts, perhaps, enter the circulation of the mother, trigger clotting within her blood system that uses up the clotting factors, exhausts their supply, so that the patient then begins to bleed heavily and will require a treatment of blood products in order to replenish the clotting factors and stop the bleeding.

Then there are later complications having to do with retained tissue and/or infection. If there is retained pregnancy tissue, there is great risk for infection, and infection can also occur without having retained tissue. We routinely use antibiotics in a preventive way to try and prevent infection. I have listed all of these terrible complications, and I would also add that they are quite rare, fortunately.

Q Looking at a D & E procedure, do you know if that, if you, in general, take into account all these risks, is it safer or more dangerous than childbirth?

A Well, the risk of all abortion procedures has to do greatly with gestational age. First trimester procedures are [p. 34] markedly safer than childbirth, the risk of death from first trimester procedures being considerably less than one maternal death per 100,000 legal-induced abortions in the United States, compared to a maternal mortality rate, that's from pregnancy, that are around seven, eight per 100,000. That risk rises as the gestational age progresses. At 16 to 20 weeks, the risk of death is still somewhat less than the risk of pregnancy, death from abortion. Beyond 20 weeks, 21 weeks, somewhere in there, the reported risk of death from abortions may exceed the risk of death in childbirth. I say may because the number of cases are small, and some of the women who are choosing those late abortions have major life threatening illnesses which put them at far greater risk than other women for death from childbirth.

Q Thank you. How late in pregnancy can a D & E technique be used?

A Well, D & E technique, as I have described it, can be used probably through 23, 24, weeks but it gets progressively more difficult. Fetus is larger, more rigid. The bones are now ossified and are no longer soft cartilage. It becomes much more difficult to perform. As a result of that, people who provide surgical abortion after 20 weeks typically modify the procedure in any of a variety of ways to make it easier to perform and safer for the pregnant woman.

Q How do they modify the technique?

[p. 35] A Well, one of the ways is, the reason we are here today having to do with this recently-evolved intact D & E variation where instead of just reaching up with a forceps and trying to remove pieces of the fetus, one tries to deliver the fetus intact. One way to do that is to use the laminaria, the dilators that I talked about, successive sets of those dilators over two or three days, allowing one set to work overnight, taking them out the next day, putting still more dilators into the now somewhat dilated cervix, and then repeating this a third time so that by then, the cervix is two, three, four centimeters dilated, fairly large opening, without injury to the cervix. Then a medication is given to cause the uterus to begin to contract, typically one of the Prostaglandins although it could be intravenous Oxytocin in high doses. Then depending on how the fetus presents, either through procedures as performed, if the fetus is presenting head first, which is probably more often the case, one can insert an instrument into the fetal skull and allow the brain content to come out. The head then collapses, and one then can pull the whole fetus out of the uterus immediately, and then reach up and pull the placenta out, and the procedure is done very quickly with very little blood loss, very little risk to the mother of perforation.

The alternative is the one which, in the lay press, has been called a partial-birth abortion, where the fetus is [p. 36] either presenting by the breech, that is, feet first or one converts it to a breech by reaching up with fingers or instruments, locating the feet, pulling them down, then pulls feet down, arms down, and then with traction so that the head is now just above the cervical opening,

inserts an instrument, scissors into the skull, and lets the brain tissue come out or aspirates it with a cannula, and the head collapses, and the fetus is delivered. This is a technique that's evolved fairly recently. Prior to that a number of things had been done. Go back historically, perhaps the first was in England where for these late procedures, the surgeon would have, after the cervix was dilated, intentionally rupture the membranes of the amniotic sac, drain the fluid and pull down the umbilical cord if it could be reached, cut it, and then just pack the cervix with gauze and wait two or three days. The fetus, now dead or would die, and begin, to decompose and soften, and the uterus would begin to contract so then the operator would bring the patient back two or three days later and evacuate the uterus. That procedure was done, was reported in the medical literature in England. It has been done to some extent in this country but has been abandoned because it occasionally is associated with very severe infection. One is leaving pregnancy tissue into the uterus and potentially introducing bacteria from below which is not a good idea.

[p. 37] Q Are there any procedures done later in pregnancy that don't involve forceps at all or instruments?

A Yes. There are a variety of labor-induction methods. The first of those to be practical was the use of concentrated salt solution, saline procedure where an amniocentesis is performed, a needle is guided through the mother's abdominal wall, through the wall of the uterus and into the sac of fluid that surrounds the fetus. Some of that fluid is withdrawn and then typically 200 cc's of 20% sodium chloride was instilled into the uterine

cavity. That would produce fetal death and trigger the onset of labor, so that on an average of 30, 35 hours of labor, the patient would expel the fetus and placenta.

Over the years, that technique was modified. The Prostaglandin hormones were introduced which directly caused the uterus to contract. There are a variety of things that can be given by a variety of routes. Initially, they were given by the intra-amniotic injection the same way the saline was given, but then more recently we have had Prostaglandins that could be given intramuscularly or just inserted into the vagina where they are absorbed into the system and will cause labor to begin.

Q How long does that, does a labor induction procedure take?

A Well, that's not a short answer either. The saline [p. 38] method by itself was an average 30, 35 hours, but it could take 70 in some women or longer and didn't always work. The saline can be augmented or added to by adding intravenous Oxytocin which we have had for a long time, or by adding Prostaglandins to make the procedure shorter. With modern Prostaglandin methods, the average time to abortion from when the Prostaglandin therapy is begun is on the order of 15, 16 hours, but that's an average. There are some women that will abort more quickly. There are some that will take much longer.

Q What does the woman experience during the – from the time the Prostaglandin is first given to her until the fetus is delivered?

A Strong uterine contractions, labor pains.

Q And what type of setting is an induction procedure done in?

A Hospital.

Q I'm going to come back to the intact procedure you described, but I first want to ask you, in your career, have abortion methods changed over the course of time? For example, the D & E, has that been the same throughout your practice, or has it changed?

A No. These techniques have evolved over the years as you might expect. Abortion became legal throughout the United States not until '73, although it was allowed in a number of [p. 39] states for a number of indications prior to that. There was very little interest in the medical profession in this country in safe methods for abortion. With legalization, there's a rapid introduction of technologies and a whole array of technologies have been introduced and perfected.

Q I want to ask you whether you consider the intact procedure you described, that is, when the fetus is removed in one piece rather than fragments, do you consider that to be a type of D & E procedure or something altogether different?

A The type of D & E procedure?

Q Could you describe why you consider it a type of D & E procedure?

A Well, it's basically the same instruments, the same process, just a variation and, in fact, the surgeon who made the attempting to – whose goal is to perform an intact D & E often finds that he cannot, that the

anatomy is just such that he cannot do it without avulsing pieces of the fetus.

Q Have you ever used the intact variation of the D & E yourself?

A I have used it in a case that I recall where the fetus was already dead and where I decompressed the head.

Q In a case where the fetus is already dead, is there any reason that you, can think of that it would be safer to remove the fetus in parts than intact?

[p. 40] A None whatsoever.

Q In talking about the procedure in which you removed the fetus intact, let's take the – I think the second example you gave where there is a feet first removal of the fetus.

A Yes.

Q Does that involve, when you say more or less use of instruments than the standard D & E involving fragmentation?

A Less use of instruments.

Q Do you have an opinion about whether that would increase or decrease risk of perforation of the woman's uterus?

MR. SMITH: I'm going to object to that; lack of sufficient foundation that he would have adequate expertise on that he's never performed it, no foundation on any studies or statistical basis for the conclusion.

THE COURT: Overruled. You may answer.

THE WITNESS: I would perhaps start by saying, I would base my opinion partly on the testimony and presentations I've read and heard in meetings of two physicians who describe, in one case, I think something over a thousand procedures, 2,000 procedures, and in the other case, 700 or so procedures with no perforations or major injury prior to 24 weeks. The intact D & E is a recent development. It makes sense to think that doing the steps that these physicians have described would make it easier to evacuate the uterus without as many insertions of the [p. 41] instruments, and that that, theoretically, would be safer. It would be a while before we have the data to compare to say how important that really is, but a series of now probably adds up to 2,700 cases or something less without a major complication except those beyond 24 weeks is a very impressive record for a late abortion procedure.

Q What would be the risk? I'm talking about risks you talked about in the D & E procedure, the one where there is dismemberment? What would be the risk in your opinion of an intact D & E of leaving fetal tissue behind as compared to D & E?

A There would be no risk of leaving fetal – of leaving part of the fetus itself behind because you would see it all intact and recognize whether or not it was complete. With any of these procedures, part of the placenta could be left. That isn't changed by doing the intact D & E procedure, and the placenta is of fetal origin. That's dilating a bit on your question.

Q Could you explain what the significance is of the placenta being of fetal origin?

A Your question had to do with whether there would be fetal remains with D & E, and I wanted to be correct as possible. When conception occurs and the embryo begins to develop, the fertilized embryo very quickly separates into two areas, a central flat disk that is going to develop into [p. 42] the fetus, and the rest is extraembryonic or outside of the embryo but of fetal origin which gives rise to the placenta and the membranes.

Q Does that mean that the placenta has the same genetic material as the fetus in some sense?

A Exactly.

Q Rather than the mother's?

A Exactly.

Q So in either the intact D & E or intact procedure and the D & E involving piece-by-piece removal of the fetus, there is a risk of leaving placental tissue behind?

A Yes.

Q Do you have an opinion about whether in the one procedure you described where the head is coming after the rest of the fetal body and the physician decompresses the head using a scissors or some other instrument, is there a risk, in your opinion, of injuring the mother when the doctor is inserting the sharp instrument into the fetus?

MR. SMITH: Well, he just asked, do you have an opinion. Okay. Go ahead. Sorry.

THE DEFENDANT: Do I have an opinion? Yes.

BY MR. HELLER:

Q What is your opinion?

MR. SMITH: Now I object; no proper and sufficient foundation.

[p. 43] THE COURT: Overruled. You may answer.

THE WITNESS: As I have heard the procedure described, the base of the skull is visible to the operator at the upper end of the cervical canal. It's possible with direct vision to slide the instrument up between the operator's fingers to enter the fetal head. That said, there is no surgical procedure but what somebody can do it wrong, and, you know, I mean, yes, you can injure anybody doing fairly simple things, but it should be a very, very uncommon event.

Q When you talked about induction procedures involving just Prostaglandin, I think you also talked about the saline portions, does it ever happen that that procedure doesn't abort the pregnancy?

A Yes, it does.

Q What happens then?

A Well, back in the old days, we would do a major surgical procedure. We would do an abdominal hysterotomy which is basically a small scale cesarean section, has just as much effect on the woman or more as doing a cesarean section, but we learned over the years that we could do a D & E under those circumstances, that even if

the pregnancy were fairly well along, the cervix by now would be dilated, the fetus would have died and macerated, become soft, and with the technique that we had learned for the D & E, we could safely [p. 44] evacuate those pregnancies and not have to do a major abdominal surgery.

Q Sorry for that diversion. I want to return to intact procedure for a moment. Do you consider the intact D & E procedure, either one, feet first or head first that you've described, do you consider that to be a safe method of doing abortion?

A Yes, I did.

Q Would you use it yourself?

A Yes, I plan to.

Q Can you – Are there situations where you might choose that method in order to preserve a woman's fertility; in other words – Let me be more clear about that. Have you, in instances where a woman's fertility was threatened by a pregnancy, are you familiar with any such cases?

A Yes.

Q Can you describe a situation where that would rise?

A The case that I can describe that I managed last year, not only was the woman's fertility at risk, but her life was at risk.

Q Can you describe that situation?

A This was a patient referred to us who had a rare, awful complication of an amniocentesis done for genetic indications. She had an amniocentesis done outside of our center to diagnose Downs Syndrome for which she was at risk [p. 45] because of advanced age, and in retrospect, we know that the needle went through the intestine of the mother. The patient presented to another hospital about 48 hours after the amniocentesis in advanced infection, very severe infection with a lung disease and kidney disease resulting. She was transferred to our facility, and we were faced with the difficult situation of trying to stabilize this woman with advanced sepsis and then evacuate the uterus which was the source of the infection, and this is the case where I personally did a variation of intact D & E. We, in the intensive care unit, started intravenous Oxytocin to make the uterus contract, put several laminaria tents into the cervix to cause it to dilate, and then about five hours later moved her to the operating room, removed the laminaria, and I was relieved to see the cervix had dilated quite a bit, and the fetal head was presenting. I was able to just put an instrument called a tinaculum which is the sharp end on the fetal head, piercing it, and the brain tissue came out, and the fetus then came out and the placenta came out.

The fetus had died a little bit before that. The mother got somewhat better after our procedure but was still seriously ill the next day, and we determined that her only chance of survival lay in us removing the uterus, so we did extract it the following day. Indeed, there was an abscess, a collection of pus within the wall of the uterus where the [p. 46] needle had entered the uterus, and it had gone through the bowel. The woman did survive.

She was in intensive care unit for six weeks but did survive, so certainly, her fertility was at risk, and she lost it. She ended up losing her uterus. If my initial procedure had been successful, then her fertility would have been saved as well as her life.

Q In that case you've described, did you know – To what degree of certainty do you know that she would die if you hadn't done the procedure?

A Well, I don't. People that – even young people that have ADRS, adult respiratory distress syndrome in response to infection, with expert management of the infection, about half, 60% die. The best we can do, they die. If the infection is not eradicated, probably all would die. First principle, one of the first principles of treating an advanced infection is to eradicate the source of the infection. To fail to evacuate the uterus, I don't know of any survivors in the few cases that I'm aware of where that happened.

Q Could you evacuate the uterus and – Well, I withdraw the question. You have mentioned two other procedures in the course of your testimony. One is abdominal, I think abdominal hysterotomy. The other was hysterectomy?

A Correct.

Q Are those procedures used to terminate pregnancies?

[p. 47] A Formerly, yes, but with the careful work of the Centers for Disease Control, the branch of our government, studies of legal abortion were performed

through the 1970s and early 80s, and these studies demonstrated that the risk of serious complications and death from these major surgical procedures, hysterotomy or hysterectomy, far, far exceeded the risk of death to the mother from doing the other abortion techniques, the vacuum curettage or D & E or saline or other labor – induction methods. That the risk to the mother was many-fold greater from major surgical procedure. Consequently, those procedures have pretty well died out. They are only used to provide abortions. They are only used in exceptional circumstances.

Q What would be an example of an exceptional circumstance?

A Oh, I quite frankly can't think of one that I would not manage in another way, but it is accepted that, for example, if someone with an extensive premalignant lesion of the cervix, extensive carcinoma in situ of the cervix where you know surgery is going to be indicated, and the woman has an advanced pregnancy, that it is acceptable just to move right to the hysterectomy and take care of both things at the same time.

MR. HELLER: I want to show you – If I may approach the witness?

THE COURT: You may.

[p. 48] BY MR. HELLER:

Q – exhibit 24 which has been received into evidence.

THE COURT: May I have Exhibit 24, please? No, no. Is there a copy for me?

MR. HELLER: I don't know if there is.

THE COURT: That's all right. Go ahead. Don't worry about it.

THE COURT: Mr. Smith, do you need that?

MR. SMITH: I'm sufficiently familiar with it that you can have it.

THE COURT: All right. Thanks. Thank you.

BY MR. HELLER:

Q Dr. Stubblefield, have you seen that document before?

A Yes, I have.

Q Can you identify it, please?

A It's a statement of policy issued by the executive board of the American College of Obstetricians and Gynecologists.

Q Does that statement describe abortion procedure?

A Yes.

Q Is it your – Does that – Have you described that procedure today?

A Yes.

Q What would you call the procedure that is described in this statement?

A It's one of the two variations of intact D & E.

[p. 49] Q If you turn to the second page of that exhibit, would you, just to yourself, read that paragraph?

Do you agree with that document's statement that the procedure described in it may be appropriate, may be the most appropriate procedure for some cases?

A Yes.

Q Do you know what the status is of a document like this from the American College of Obstetricians and Gynecologists? What is the meaning of this type of statement?

MR. SMITH: Just for clearness, are you talking the policy in its entirety?

MR. HELLER: Well, let me be more clear with that question.

BY MR. HELLER:

Q Do you know if this type of document has any particular status within ACOG's heirarchy?

A Well, in general, Fellows who make up the organization are guided by such policy statements. They are never meant to supersede the judgment of individual physician, and the ones that are labeled as practice guidelines always bear a disclaimer at the bottom that says exactly that, that they are not meant to establish a medical-legal standard or to be the only thing that someone can do. I don't remember the wording, but they certainly are a guide to practice.

Q I want to talk to you a little bit and ask you some [p. 50] questions about circumstances under which women obtain later abortions. Let me start by saying something like, Doctor, 16 weeks, can you describe some

of the circumstances that would lead a woman to request an abortion after 16 weeks of pregnancy?

A Well, there is a wide range. I think the most common association with later abortion is youthfulness. The young woman who is herself physically well and does not have an abnormal pregnancy, but it is for her one that she does not wish to continue for any of a list of reasons, but because she is young, she delays in admitting that she has a problem. She delays in seeking help. In many states there are barriers that make it legally difficult for her to obtain that help and ends up into mid pregnancy before she is able to reach a provider who will provide abortion for her. There is a range of other circumstances that I've seen over the years. Women who are finally deciding to leave their abusive spouse who has beaten them one more time, and this was the one time they just couldn't put up with any longer. Spouses abandoned when a pregnancy, quite frequently, in my perspective, women may develop a serious disease or one may get worse in the pregnancy. The patient may not have even known that she had the disease before until she becomes pregnant, and when you add changes of pregnancy now, the disease becomes manifest, and she has reached a [p. 51] decision whether she will take the risk of continuing the pregnancy or terminate it. Fetal malformations is another one that we deal with not infrequently, the most common of those being Downs Syndrome, but there are a whole long list of others that can now be diagnosed through the advances of science and diagnosis. There are a long list of conditions that are very, very serious, life threatening, that will seriously affect the quality of life of a fetus should it survive and be born,

and where parents are given the opportunity, may choose to abort or may choose to continue the pregnancy.

Q Have you ever had a request from another medical professional for an intact fetus after an abortion?

A Yes, I have.

Q What are the circumstances of that, sir?

A The circumstances are, this latter group of cases I described where a fetal malformation has been diagnosed and the geneticist or internal medicine specialist who has made the diagnosis wants an intact fetus so that it's easy for the pathologist to examine the fetus and confirm the diagnosis. In the past, not knowing about the D & E procedure, I have generally declined to honor that request feeling that in my hands, the D & E procedure was safer and easier on the woman than going through labor induction. Now that this new technique is available, were I in this circumstance now, I [p. 52] think I would try to provide the intact D & E.

Q In talking about D & E's versus induction abortions, are there any situations in which an induction abortion is dangerous for a woman or not contraindicated for a particular individual?

A Well, there are certain circumstances where there isn't any real good way out, but, for example, with a woman whose fetus has severe hydrocephalus or water on the brain, when the head is tremendously distended and swollen, to induce labor isn't really going to work. The woman is not going to be able to expel that fetus until the fetus dies and the head begins to be depressed unless you decompress the head yourself.

Q Are there any health conditions where you wouldn't want to administer the particular drugs that are necessary for the induction like Prostaglandin?

A Yes, there are. There are a variety of circumstances, women with severe heart disease, for example, where the labor itself or the drugs could be a problem. The Prostaglandins that we have typically used, Prostaglandin E2 and Prostaglandin F2 Alpha have significant cardiovascular effects, and the woman who already is, for example, in heart failure, it would be somewhat frightening to use them. There is a newer Prostaglandin. This is a bit of a technical discussion, E1, which is Misoprostol which may well be safer. [p. 53] We don't have any experience with it yet, and women with these kinds of problems, but to do an D & E avoiding those medications, the D & E can be done without major anesthetic. It can be done fairly easily with what we call conscious sedation which are low doses of a sedative and pain relieving medications which are really quite safe, given intravenously. One could be a D & E or intact D & E in most of these circumstances and avoid using those drugs and be of benefit to the woman.

Q Dr. Stubblefield, I want to read to you now the definition of partial-birth abortion in the Nebraska statute that is at issue in this case. The statute says, "Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living, unborn child, before killing the unborn child and completing the delivery." The statute then goes on a little bit further. "For purposes of this subdivision, the term partially delivers vaginally a living, unborn child, before killing the unborn child means deliberately

and intentionally delivering into the vagina a living, unborn child, or a substantial portion thereof for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." Now, I want to start with some of these terms and ask you if you have an understanding of them.

[p. 54] THE COURT: Counsel, before you do, it's about 10:25. Give me a sense of how much longer you'll be with this witness.

MR. HELLER: I think at most 20 minutes, Your Honor.

THE COURT: All right. Let's take our mid morning break now, if you don't mind.

MR. HELLER: No, no.

THE COURT: We'll come back in 15 minutes, and we'll conclude this witness's testimony at that time. We stand in recess. Let me see counsel at the bench, please. Sir, you may step down. (Recess from 10:25 to 10:40 a.m.; all parties present)

THE COURT: You may proceed.

BY MR. HELLER:

Q Thank you, Your Honor. Dr. Stubblefield, before the break I had just read to you a definition from the Nebraska statute of partial-birth abortion. I want to ask you some questions about that definition. First, is the term partial-birth abortion a term you've encountered in medical textbooks or articles?

A No.

Q The next part of the definition I want to ask you about is the phrase partially delivers vaginally. Can you describe what your understanding is of delivers vaginally?

[p. 55] A Well, in the case of delivering a baby at term, a vaginal delivery refers to helping the baby come out of the mother. I'm guessing that the legislators had something like that in mind. To deliver means to present, put in front of you.There is no medical meaning to these. These are words that a nonmedical person has made up. I presume they mean pull a piece of the fetus down into the vagina and out of the vagina.

Q The definition says that partially delivers vaginally a living, unborn child, means deliberately and intentionally delivering into the vagina a living, unborn child, or a substantial portion thereof. It goes on, but I want to ask you some questions about that. What would it mean to deliver into the vagina a living, unborn child, in your view?

A Pull, pull the fetus down into the vagina.

Q So from your prior testimony, do I understand correctly, that means taking the fetus from within the uterus and through the cervix into the vagina?

A Yes.

Q It doesn't necessarily mean out of the woman's body completely?

A You're right. It doesn't say that, correct.

Q Now, then, the statute also talks about deliberately and intentionally delivering into the vagina a substantial portion of a living, unborn child. What is your [p. 56] understanding of what would constitute a substantial portion of a living, unborn child?

A Subject to opinion. There is no legal or medical definition of what constitutes a substantial portion of an unborn child.

Q The statute then goes on to say that all of this has to be done for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child. I want to ask you, in which types of abortion procedures does the physician know that the procedure will kill the unborn child?

A All of the surgical abortion procedures, vacuum curettage, all variations of a D & E.

Q What about a first trimester procedure?

A Yes.

Q Are there types of abortion procedures that do not involve delivery into the vagina of a living, unborn child, or a substantial portion thereof?

A Well, the only thing that I can – The only way I can think of to avoid that, there are two ways. One would be to always do an abdominal operation so that nothing is delivered into the vagina, or do something that will cause fetal demise prior to the abortion procedure in every case.

Q So in the first case, you're saying that it would be to avoid the law because it's not through the vagina. It's [p. 57] through the abdomen?

A Correct.

Q That the fetus is delivered. What procedures – what are the procedures you can do abdominally?

A Hysterotomy and hysterectomy.

Q Those are the procedures you testified to earlier are significantly riskier for women?

A Definitely.

Q The alternative of fetal death or fetal demise, I take it, you think that avoids the statute because they are – you're not delivering the unborn child?

A Correct.

Q How would you – How would one bring about fetal death prior to getting an abortion procedure?

A Amniocentesis and attempt to inject into the fetus a substance such as potassium chloride or Digoxin to stop the heart of the fetus.

Q Are there any risks that you're aware of in performing such an injection into the fetus?

A Yes, there are.

Q What would those risks be?

A One of them is just the passing of the needle, as the case that I just described illustrates. Rarely, but for real, the needle may traverse the bowel which is full of

bacteria and then carry those bacteria into the uterus where [p. 58] they are protected from the body's immune system and can cause rapidly progressing infection. One could also spear a blood vessel and cause significant bleeding with amniocentesis. The substances themselves seem to be harmless if they are injected into the fetus, but if they were inappropriately injected and enter the mother's bloodstream, they could be dangerous to her.

Q Are there any benefits to causing fetal death by such an injection?

A Those kinds of procedures are done typically after 20 weeks, and there is an advantage at that point on in allowing an easier evacuation procedure.

Q How does that work? Why is it easier?

A If one does this, one variation of a D & E is to use laminaria over two or three days, and at the start of the procedure to do an amniocentesis, inject Digoxin or potassium chloride into the fetus to produce fetal death, then not perform the actual abortion for another couple of days, so during that time there is time for the fetal body to begin to decompose and soften so it will be easier to remove with the instruments. That is done, not uncommonly, after 20 weeks. To try to do it at eight weeks would be ridiculous. It would be hard to do, take great skill to do it. You couldn't do it predictably without injuring the mother.

Q Do I understand you then to say that the risks to the [p. 59] mother increase, the smaller the fetus is, the earlier the pregnancy is?

A If you you [sic] are trying to insert the needle through the abdominal wall of the mother and avoid injuring her, yes.

Q No benefit?

A No benefit, no benefit except to the doctor going to jail and losing your license and livelihood.

Q Now, if the Nebraska definition that I described to you were in effect in Massachusetts where you practice, what effect would that have on your practice? What would – How might it change your practice?

A I think we would probably have to stop providing this service until the courts clarified what exactly is meant medically by these words.

Q Now, I want you to assume for the moment that the Court clarifies these words which you've indicated could apply to any abortion other than an abdominal one or one where there is fetal demise. Suppose the Court clarified those words to say that all this prohibits is just an intact D & E either with feet first or head first, one of those procedures, but it prohibits both of those. What effect would that type of prohibition have on your practice?

MR. SMITH: Just going to interpose a *foundational* objection. I don't think it's relevant. It's speculation, assuming what the Court would do.

[p. 60] THE COURT: Overruled. You may answer.

THE WITNESS: My service is presently not going beyond 20 weeks. Again, if you want a long

answer, I can tell you what I have been thinking about as director of the service. Presently, between 16 and 20 weeks, we hospitalize the patient for a labor induction abortion with Prostaglandin. We stop our D & E's at 16 weeks. I have been planning, now that I have hired new staff in the last few months, to try to extend our D & E's to 20 weeks and stop doing the hospital ones. Part of that is a cost saving measure, expends a lot of hospital resources, many thousands of dollars to care for a patient in the hospital, and for patient convenience does not have to be admitted to the hospital. Patients don't like that, so I have been actively thinking that we would try to adopt some variation of intact D & E in order to make it easier on ourselves, our patients, and our residents to provide D & E in that range, the 16- to 20-week range. Obviously, if this law works and exists in its present form in Massachusetts, we would not be able to do that.

BY MR. HELLER:

Q Why would you, in making a transition from your current practice in your abortion service to a new way of doing abortions from 16 to 20 weeks, why would you choose an intact D & E procedure?

[p. 61] A Because as it has been described to me, it sounds like it would be easier consistently to do, easier for the patient and easier for the physician, and if I add this procedure, I would be dealing with trainees, residents in training, who want to have something that is safe and easy for them to consistently perform. Also, I would like other physicians to be able to do it. You know, selfishly, myself, I don't want – I would like to make the

commitment to the patients that we'll provide this service. I don't want to tie me up all the time doing it. I would like other people – I know I can do these by standard D & E. I have done it for years. I would like a simpler, easier technique.

Q And you've testified earlier that your opinion was that there might be less risk of perforation and less risk of fetal tissue left behind with the intact procedure. Are those the reasons you believe it might be safer for women to have that procedure?

A Those, plus I believe that there should be less likelihood of the rare but devastating complications of the blood clotting abnormality, the DIC and the still less common amniotic fluid embolism.

Q Why would you think those rare complications might be less?

A Because I believe that they relate to fetal tissue entering the mother's circulation during the performance of [p. 62] the abortion. If there are less manipulations within the uterus, less fetal tissue within the uterus less, specifically brain tissue within the uterus that enter the mother's circulation, less risk of those complications.

Q Going back to the – Let's assume there is no court interpretation of the statute. You're just going on what you understand the words to mean. Is there some – Well, suppose someone were to say that substantial portion in the statute means more than a little bit of the fetus. What would you understand that to mean?

A It sounds like they would be precluding most surgical abortions, making it illegal.

Q I just have a couple more questions, and I think I will be done. Do you have any reason to believe that the intact D & E procedure is less safe than the standard D & E procedure involving removal of the fetus in parts?

A No.

Q Do you have any reason to believe that the intact D & E procedure is less safe than an induction procedure using Prostaglandin or other drugs to induce delivery?

A At equal gestational ages?

Q Yes.

A No, I do not.

Q Would you have any hesitation using intact D & E procedure to remove a dead fetus?

[p. 63] A No, I would not. I would not hesitate to use it.

Q One other thing you testified about earlier, I wanted to clarify. You talked about situations where the head of the fetus would have to be compressed or made smaller. Why couldn't one just pull the head out without compressing it in either a D & E or an intact D & E?

A Because of the resistance of the cervix. The cervix is only minimally dilated. The cervix is not dilated as much as the head is.

Q Are there other parts of the fetus that are also too large to pull out through the cervix?

A The diameter at the hips is almost but not quite as great, and that typically will come through if – It's

kind of a physics motion problem, but if the – if you will, the body is tapered either way, and if you are – That does not turn out to be a problem.

Q Is there any reason you just don't dilate the woman's cervix more until the entire head can come out?

A It takes quite a bit more time to do that, and during that time, there begins to be risk for infection. There is – you're delaying the process, still further risk for bleeding. Just not practical to do it.

Q How is the fetal head removed in an ordinary D & E that is not intact? How does the head get removed?

A You crush it with the forceps and then remove it.

[p. 64] Q In a standard D & E where you crush the head or you have removed other parts, are there – Is there any meaningful difference between crushing the head and removing the contents with a through suction?

A No, there isn't.

Q Is there any risk in a standard D & E from, in later pregnancy, from bones of the fetus or sharp parts of the fetus?

A Yes. With the more advanced gestations, as you're trying to crush and pull out the skull or long bones, one, you can lacerate the cervix with those fetal parts as you're pulling out.

Q Would that risk be the same with the intact D & E?

A No, it would be less.

MR. HELLER: No further questions, Your Honor.

THE COURT: You may inquire.

CROSS-EXAMINATION

BY MR. SMITH:

Q Thank you, Your Honor. Dr. Stubblefield, just some questions that at least weren't clear to me as far as your actual abortion experience. As I understood your testimony, is that you supervise in some supervisory capacity 1,500 to 2,000 abortions a year at present?

A That's correct. They are performed on my service.

Q Okay. Now, supervision can be direct where you're [p. 65] actually present, or indirect where you are not even, frankly, on the premises. What are the numbers of abortions where you are either performing them yourself or are there directly supervising?

A That is, as I said, I cover our little abortion unit, I think I said once or twice a month, and we will typically perform eight or 10 procedures, in that range, at each of those sessions. The way it's organized, the attending, which would be me in that case, turns up at 8:00 o'clock, and we'll begin. Residents are finishing rounds up on labor and delivery, so I will do two or three procedures myself, and then the resident appears around 9:00 o'clock, and the rest of them are done by the resident with me coaching them. I whisper in their ears, and if they are getting into difficulties, then I take over get them by the difficulty and guide them through the procedure.

Q So it would be accurate that you either perform or directly supervise the performance of approximately eight to 10 abortions per month at the present time?

A Depending on the month, might be 20, might be 10.

Q And that has been the case for approximately how long?

A Three years.

Q A couple of questions about the American College of Obstetricians and Gynecologists. I believe you said you had to be board certified to be admitted to ACOG?

[p. 66] A To be a Fellow, yes. You can be a junior Fellow after you finish training before you pass the boards.

Q And you said you are a member. Do you mean by member you are a Fellow?

A I'm a Fellow.

Q And the board certification that is necessary to be admitted to ACOG comes from where?

A From the American Board of Obstetrics and Gynecologists.

Q And is that a specialty organization affiliated with the American Medical Association?

A Yes. For each of the disciplines there is a licensing board that operate under an umbrella organization called, I think, the ACGME, the Accreditation Counsel and Graduate Medical Education.

Q When you say discipline, you mean a medical specialty?

A Yes.

Q And to become board certified, I take it, you would have had to have passed some type of certifying examination?

A Yes. To be eligible for the board, you've got to have completed the four years of post-graduate training after medical school in the residency that's approved by yet another organization called the Accreditation Council for – well, a different outfit under the ACGME. You have to graduate from the the [sic] approved residency in good standing. You then take a written exam the summer after finishing the [p. 67] residency. If you pass that written exam, you're then, you enter a sort of a probationary period where you practice as a specialist. You collect your cases, you submit your case list of every patient you've delivered or every surgery that you've done to the board, and if they agree that you've done a sufficient number, then you're allowed to sit for the oral exam which is – typically occurs about two years after you've completed residency training in the usual sequence.

Q And physicians who are board certified in obstetrics and gynecology, what's the criteria for them to go the next step to become Fellows or members of the American College of Obstetricians and Gynecologists?

A The process involves filling out some forms, documenting your education and board status, and getting two local Fellows in the community to propose and

endorse you, and then these papers are all reviewed, and you're admitted or not admitted.

Q So it would be an accurate statement that not all board-certified physicians are ACOG members, correct?

A That's correct, although the vast majority are.

Q Now, the various abortion procedures that you testified to, would you describe all of them as surgical procedures with the exception of the pharmaceutical abortions?

A Yes.

Q And the pharmaceutical abortions would be the RU 486, [p. 68] the Methotrexate?

A Correct, and the labor induction abortions are also pharmaceutical abortions performed later in pregnancy with the Prostaglandins.

Q When you were describing the vacuum curettage method of abortion, at least my note was, you referred to the fetus living outside the uterus while in the cannula. At least that can happen?

A Yes.

Q What did you mean by the fetus living?

A Well, I mean, the heart could still be beating for a period of time.

Q So would your definition of a fetus living being a fetus heartbeat?

A That's the best one I can come up with, yes, sir.

Q Is that generally recognized by the medical profession?

A To my knowledge, there are no expert committee statements on that issue.

Q At least your peers or those that perform abortion, do you know if a fetus living, fetal heartbeat is synonymous with a living fetus?

A If it's intrauterine gestation, then it certainly is accepted, the fetus heart as beating is living.

Q If there is, no fetal heartbeat?

A The question you're describing –

[p. 69] Q Go ahead.

A I was going to say where we have an abortion in process and pieces of the fetus coming out, no one, to my knowledge, has tried to formally address what is living or not living in that context.

Q Now, you gave some various statistical rates in your testimony as far as risk of death in abortion. I had one in a hundred thousand risk of death from abortion versus childbirth. Where did you come up with those statistics?

A Probably the most succinct way to answer that question is to refer to the American Medical Association report which I believe has been placed in evidence. That report summarizes in one place two bodies of data, publications from the Centers for Disease Control, the government agency in Atlanta, and annual surveys by the Alan Guttmacher Institute in New York City which also tracks numbers of abortions.

Q If I could approach the witness, Your Honor.

THE COURT: Yeah. Counsel, for your information that also is reprinted in our previous opinion and described, at least, planning effect 64, I believe.

MR. SMITH: My purpose is just to make sure that this [sic] what we understand in this witness's – what his basis is, what he's relying upon.

THE COURT: Sure. Go ahead.

BY MR. SMITH:

[p. 70] Q Doctor, showing you Exhibit 6, would that be the portion of the AMA report containing the statistical data you relied upon for risk of maternal death?

A Yes.

Q That's from abortion?

A Correct.

Q Now, in your testimony when you were talking about an intact D & E, you used the term recent development. How recent of a development?

A I believe 1995 is the year that Dr. McMahon made a presentation at the meeting of the National Abortion Federation, April of that year, I believe. There is Dr. Haskell who made a presentation. I'm not sure whether it was in the same year or a subsequent year.

Q And during your testimony on direct, you referred to presentations at meetings, medical papers. Would that be presentations by Dr. McMahon and Dr. Haskell?

A I'm not exactly sure what you're referring to.

Q Okay.

A In my testimony.

Q Okay. In reference to your knowledge of the intact D & E procedure, you referred to some paper presentations at meetings. I'm just trying to understand who made the presentations.

A McMahon and Haskell.

[p. 71] Q And as far as the credentials for Dr. McMahon and Dr. Haskell, do you know if Dr. McMahon is board certified?

A I do not know.

Q Do you know if Dr. Haskell is board certified?

A I think Dr. Haskell, if I'm not mistaken, is a family physician, and whether or not he is board certified in that, I do not know.

Q And the presentations, were they actually physically present when they made their presentations?

A Yes.

Q The presentations were made at what organization?

A National Abortion Federation.

Q And these presentations, would these have been presenting papers?

A Yes.

Q Okay. And also oral presentation?

A They were oral presentations.

Q And prior to that time, as far as your knowledge or awareness of the intact D & E abortion procedures that were described in their presentations, did you have any knowledge of such a procedure?

A No, I did not.

MR. SMITH: I'm looking for Exhibit 24 is what I'm looking for.

THE COURT: Is 24 the –

[p. 72] MR. SMITH: It's the policy statement.

THE COURT: You have your copy.

MR. SMITH: I don't need my copy. I wanted to have the one for the witness. If I could approach the witness?

THE COURT: You may.

BY MR. SMITH:

Q Dr. Stubblefield, showing you what is marked as Exhibit 25, the ACOG policy statement, that statement refers to an abortion procedure described as an intact dilatation and extraction procedure, correct?

A Correct.

MR. HELLER: May I just note, I think it's Exhibit 24, just to be clear.

MR. SMITH: I meant 24. Okay.

BY MR. SMITH:

Q Exhibit 24 is the ACOG policy statement, correct?

A Correct.

Q And it refers to the intact dilatation and extraction procedure?

A Correct.

Q And also uses the terminology for abbreviation intact D & X?

A Correct.

Q Now, the intact D & X, would that be the same procedure which you've previously testified to as the intact D & E [p. 73] procedure?

A It's one of them.

Q And how would the intact D & X procedure vary from the intact D & E which you previously testified to?

A It's really a technical point. Dr. McMahon described two variations of procedure depending on how the fetus presents, whether it's presenting head first or feet first. This describes just the version where the fetus is either presenting feet first or one is able to convert it into a feet first presentation by reaching up and pulling down the feet.

Q When you say this describes, you are talking about Exhibit 25, Exhibit 24?

A Correct.

Q So at least as far as the understanding of an intact D & X, that would be the procedure in which you were

doing an abortion in a breech manner or converting to do an abortion in a breech manner?

A It's not exclusively that. There are two procedures that are described. ACOG dealt with just one of them.

Q Okay. Well, ACOG calls the procedure an intact D & X, is that correct?

A This is true.

Q And as far, as just understanding terminology, if we are using intact D & X, that would refer to the ACOG description, [p. 74] Exhibit 24?

A But not exclusively.

Q Does ACOG have any other definition for intact D & X than appears –

A No.

Q Now, the intact D & X procedure, to your knowledge, does that appear in any medical text or peer-reviewed medical journals?

A I have added it to a chapter that I regularly write and revise, and Dr. Nichols's Textbook of Gynecologic Surgery that is in press now. It's not yet been published.

Q Prior to the AGOG policy statement in January of 1997, was the intact D & X procedure described in any medical journals or medical texts to your knowledge?

A Not to my knowledge.

Q The fact that the ACOG policy statement describes the intact D & X procedure, does that mean that

the procedure as described is generally recognized in the medical profession, not accepted, just recognized that it exists?

A I'm not – I'm not quite sure what the technical meaning of generally recognized is. The purpose of ACOG writing this was to clarify an area that was not generally known.

Q Essentially establish the policy, correct?

A Yes.

Q Now, have you ever performed an intact D & X procedure?

[p. 75] A As defined, option B as defined in the AGOG statute, feet first?

Q That's correct.

A I have not.

Q Have you ever seen it performed?

A No.

Q Are you aware of any peer-reviewed medical articles which compare the safety of the intact D & X abortion procedure as opposed to other abortion procedures?

A No.

Q Are you aware of any medical studies which compare the safety of the intact D & X abortion procedure versus other abortion procedures?

A No.

Q Do you know of any reason why there are no such studies comparing the safety of the intact D & X versus other abortion procedures?

A There are several reasons for that. Primarily, it's the novelty that this is something new. This is what happens in every area of practice. There is nothing that starts out with a large randomized trial. You can't do that until you have someone start with a pilot study where they do their procedure and perfect their procedure to the point where it's useful, and it's only appropriate at that time to try and compare it to something new. Also, there is essentially no [p. 76] funding for this kind of research.

Q Now, you testified – If I'm putting words in your mouth just correct me – but as I understand it, there are studies under way for other pharmaceutical drugs, abortion drugs?

A That's correct.

Q And the purpose for the studies, as you understand it, would be what?

A I was probably referring to use of Tomoxifen for early abortion.

Q Well, let me just ask you, there is a drug known as Amoxifen?

A Tomoxifen.

Q Tomoxifen?

A Um-hm.

Q That's a drug that's purported purpose is what?

A It would do the same thing that the RU 486 drug does but in a different way, namely, hormonally affect the pregnancy so that it will then be expelled in response to the low dose of Prostaglandin in early pregnancy.

Q And the type of studies that you're describing that are under way, what do you mean by study?

A I mean that a protocol – I mean, a single investigator in that case, Dr. Michelle, came up with the idea, presented it, wrote it out, presented it to his institutional review board that rules on the permissibility of human studies and [p. 77] carried out, treated a number of patients with the new medication in early pregnancy, carefully observed the outcome and presented it to peers, and in response to his promising findings and his pilot study, a larger national study was planned funded by the Planned Parenthood organization and is, I believe, being currently carried out in a number of centers following Dr. Michelle's protocol.

Q Would the purpose of the study be to demonstrate the safety and effectiveness of the drug?

A Yes.

Q In other words, turn it from theory to proving it as medically-accepted fact?

A Yes.

Q And has the safety of the intact D & X procedure ever been studied to the point that it has been medically-accepted fact that it is a safer abortion procedure?

A All we have thus far are the two reports from two doctors that we have mentioned who have given brief accounts of their experiences.

Q Would the answer to my question be no?

A Yes.

Q So there have been no studies yet which have confirmed that the intact D & X procedure is, in fact, a safer abortion procedure than other abortion procedures?

A Correct.

[p. 78] Q Do you believe that is necessary?

A I think it would be appropriate to do it. I think that when one has discovered a way of doing something that is so much easier than what you're already doing, that it's kind of questionable whether you really need to go to that extent. If you are struggling to open the door to a car, and I can show you how to put the key in the lock and then the door opens easily, we don't need a randomized placebo-controlled trial to show the keys are important.

Q But as far as the practice of medicine, doesn't medicine proceed on the basis that something becomes medically accepted only once it has been tested, proven, and generally recognized by the medical community?

A In the case of surgical procedures, it's not quite that orderly. Things tend to move in leaps and bounds. Sometimes surgical procedures are evaluated on a randomized basis. It would be nice to do that, but more frequently, they are not. Open heart surgery was not tested in a randomized, controlled way. People figured

out how to do it. Patients lived, they kept doing it, got better at it.

Q Would you agree that abortion surgical procedures as performed in this country, at least as you understand how they are performed, is one of the safest surgical procedures in the country?

A Yes.

[p. 79] Q And would that be the case excluding the intact D & X abortion procedure?

A I'm not quite sure where you're going with this, but the vast majority of abortions are done in first trimester, 90-some percent. The D & X procedure is not needed in the first trimester. The benefit to patients from having this procedure would fall, would be available for a smaller number of patients, basically those who undergo the procedure after 16 weeks which is something like 5% of the abortions that are done.

Q Well, the intact D & X procedure as defined by ACOG and your understanding of the D & X procedure as presented at the '95 papers presentations, prior to that time, abortions were performed in other manners in a safe manner, weren't they?

A It's not a question of relativity. By that, I mean, safe compared to what? The labor induction abortion with saline were safer than major surgery, but it were not as safe as standard D & E or as some of the Prostaglandin methods that have come along since.

Q Now, can you describe to us what your supervisory and also your direct supervisory involvement would be with medical residents?

A With –

Q I'm trying to understand your responsibilities. As I understood, you overall supervise a program which will have [p. 80] approximately 19 to 25 residents in it at one time?

A Um-hm. Sure. I'm the chairman of the department, so the responsibility, a lot of things, it is my responsibility to ensure that a variety of programs are carried out. I'm responsible for the Dean for the medical students, I'm responsible to the president of the hospital from the overall conduct of the service, but obviously, I cannot and do not do everything myself. I hire people. I try and hire the best people that I can, talk to them, look at their results, and coach them and fire them if they don't do a good job.

Q Do you have responsibility for determining what the residents are taught?

A Yes, within guidelines provided by the residency review committee in obstetrics and gynecology.

Q And do the residents at Boston University, are they presently taught the D & X procedure?

A Let me just clarify. The residents aren't at Boston University. They are at the hospital.

Q Okay.

A And they are presently not taught the D & X procedure.

Q And have the residents in your tenure with your supervisory role in the residency program, have they ever been taught the D & X abortion procedure?

A No, not yet at our institution.

Q Are they taught other abortion procedures?

[p. 81] A Yes, they have been taught standard D & E. The present residents are doing them all the way up to 16 weeks with D & E.

Q Are there any current proposals to teach the D & X abortion procedure to the residents?

A Yes.

Q And have those been accepted for approval?

A Well, I'm the one that does the approval. It's just a case of really making sure that I have the right people and the right place to make the change, and I hired a key person who started work in October, and that's our next project once we get a few other things finished.

Q Now, the partial birth abortion bill that Nebraska has, does Massachusetts have such a bill or similar bill?

A They have a similar bill, but it's different in a very important way. It does not apply until after 24 weeks of gestation, so it does not affect any previability abortion.

Q And are you generally familiar with what OBGYN residency programs in the country, what they are teaching the residents?

A Generally.

Q Are you aware of any OBGYN which is teaching the D & X abortion procedure?

A No.

Q And just to understand the residents of OBGYN programs, [p. 82] those are the physicians that are being taught the specialty for future practice?

A Correct.

Q And the purpose of a residency program would be to keep the residents up-to-date and current so they can go out and properly treat people?

A Yes.

Q I think you said this, but just my memory, to make sure I asked you, it is possible to determine whether a fetus is alive or dead before you begin an abortion procedure?

A Yes.

Q And what are the mechanisms? How you would make that determination?

A The most important one would be ultrasound.

Q And would you expect that any competent physician should be able to make that determination whether the fetus is alive or dead before performing an abortion?

A If that person has had some training in performing ultrasounds.

Q And that gets me to a question, I wasn't clear on what you said on direct. Does the physician typically, when performing an abortion, have ultrasound monitoring of the mother during the entire procedure?

A First trimester, it is very rarely used. Beyond first trimester, different physicians begin to use it in different [p. 83] gestational ages.

Q And the purpose for using it would be what?

A People, especially people who are beginning to learn the procedure, appear to be helped to guide the instruments properly by being able to visualize structures inside the uterus, especially with standard D & E when the head is the last thing removed. The uterus has started to contract, it can be difficult to locate, and the inexperienced operator might injure the uterus, whereas with ultrasound, they can see exactly where it is. With experience, one learns to feel, and there is less need for the ultrasound.

Q Would it be an accurate statement that a physician can use the ultrasound throughout the entire abortion procedure?

A That would be accurate, yes.

Q And whether or not one, one being a physician, actually uses the ultrasound throughout the entire procedure primarily depends upon the level of expertise of the physician?

A It's a trade off. The ultrasound machine is expensive. Cheapest ones are 30 or $35,000. It becomes less worthwhile to visualize as the procedure progresses. Once the amniotic fluid is gone, you don't see as well. Once the uterus starts to contract and parts are removed, you can see things less clearly with the ultrasound, so that there is variation in terms of what operators choose to do, but there are limits as to what you can see with it.

[p. 84] Q As far as the medical standard of care in this country, would it be the medical standard of care of

this country that a physician performing an abortion should always have an ultrasound to assist him?

A Should always have an ultrasound?

Q Yes.

A Not yet.

Q And are there, just trying to understand abortion procedures in which you would not be the standard of care to use an abortion procedure, are you talking about the first trimester or the entire term?

A First trimester, there is really no benefit to trying to use it to guide you during the procedure. It's helpful to have obtained one preop, but again, there is a trade off. Most abortions are paid for by the patient themselves. The charge in most hospitals or ultrasound labs for doing ultrasound considerably exceeds what abortion clinics charge for the abortion. Abortion clinics typically charge $350. An ultrasound in a hospital is 300, $350 for the radiologist, $200 for the hospital, 500 bucks, so that to insist that an ultrasound always be done is to considerably increase the cost.

Q I guess my question is, as far as the standard of care of using an ultrasound, is it – is the standard of care that an ultrasound would be used during the second and later [p. 85] trimester?

A No.

Q And by use, I'm talking about having an ultrasound examination at all.

A Well, that's different.

Q Okay. That's –

A I think – I'm not sure it's an absolute requirement, but I think that prudent physicians will generally have a preop ultrasound at some point in the early mid trimester, 13, 14, 15 weeks.

Q So reasonable –

A It's prudent to do an ultrasound.

Q A reasonably prudent physician would have an ultrasound done?

A Yes.

Q You're not a pathologist, are you?

A No.

Q Is there a subspecialty of pathology known as fetal pathology?

A I don't think there is any board certification. There are certainly individuals who spend more time studying the fetus, the placenta, pregnancy, complications.

Q Would you agree that a pathologist who performs pathologies on fetuses would be better qualified to know what he needs than you would?

[p. 86] A In terms of?

Q What he needs in order to do a proper fetal autopsy.

A Yes.

Q Would you agree that an abortion procedure is safer than a shot of penicillin?

A First trimester, clearly.

Q And do you recall that you testified in the state of Arkansas?

A Yes.

Q And do you recall this question and your giving this answer, or these questions and your giving these answers? "Is it your opinion that abortion is one of the safest surgical procedures in the United States that exists?" Answer you gave was, "Yes." Question: "Would it be even more safe than a shot of penicillin?" Answer: "Yes, it would. Approximately one in a hundred thousand patients who receive penicillin die of anaphalaxis, severe allergic reaction to penicillin."

A Yes.

Q Do you agree with those questions and answers that you gave then?

A Yes, I do.

MR. SMITH: Nothing further.

THE COURT: Redirect?

MR. HELLER: Very briefly, Your Honor.

[p. 87] REDIRECT EXAMINATION

BY MR. HELLER:

Q I want to ask you some questions to clarify some of the questions that Mr. Smith asked you. You testified a couple of times about your service at your hospital. Can you just tell the Court what you mean by the service, the service that you run?

A Well, you mean –

THE COURT: Counsel, if it makes any difference, I know what service means, but if you want to make a record, go ahead.

BY MR. HELLER:

Q If you could just briefly state –

A Do you mean our entire operation, or you mean just the abortion service.

Q The abortion service?

A Just the abortion service. We have two facilities. We have inpatient beds where we provide the labor-induction procedures, and we have really very much a small abortion clinic within our larger ambulatory care facility where we provide prenatal care, gynecological care, and we have two treatments rooms and two exam rooms, and a dedicated nursing staff where we actually perform the abortion procedures.

Q You also testified that you were not currently teaching the intact D & X method of abortion as described in Exhibit [p. 88] 24 to your residents?

A That's correct.

Q Do you teach the Methotrexate method of abortion to your residents?

A No.

Q Do you teach the RU 486 method to your residents?

A No, not yet.

Q You also testified a little bit about the difference between how surgery evolves. Do you know, does the FDA, the Food and Drug Administration require, if you know, a formal approval for new surgical techniques?

A No.

Q Do they require that for new drugs?

A Yes.

Q Is that part of the reason that drugs are studied perhaps more carefully or more formally than surgery, new drugs?

A Yes.

Q You also gave some testimony –

A I could expand on that at great length, but the FDA is not on trial today. I wish they were.

Q I agree. You testified that putting aside the intact D & X procedure or either of its two variations, the one described in Exhibit 24 or the one where the head comes out first, that putting that aside, abortion is already very safe [p. 89] in the United States, is that right?

A That's correct.

Q Is it also true that in general, medicine strives to make treatment safer and safer for patients?

A Yes.

Q And that's even if a procedure is already, quote, safe?

A Yes.

MR. HELLER: I have no further questions.

EXAMINATION

THE COURT: Doctor, before you step down, one of the criticisms, as I understand it, of the – what counsel have been referring to as the D & X procedure or the intact D & E is that it requires the insertion of a sharp instrument into the uterine cavity, at least to some small degree. In your testimony, I think you said that you didn't see that as much of a concern because you could visualize the head of the fetus when it was in the – as it was pulled down against the interior of the – of the cervical canal. Did I understand you right?

THE WITNESS: That's correct.

THE COURT: Would you explain to me?

THE WITNESS: I could try to draw it. Would that help?

THE COURT: Yeah, it really would, if you could. Perhaps the courtroom deputy will help you. Doctor, as in [p. 90] everything with the federal government, that will fall down in [sic] you aren't careful.

THE WITNESS: Just as long as it doesn't blow up, I'm all right.

THE COURT: I make no warranties.

THE WITNESS: We get to late in the procedure where that step we are talking about would be being performed. This would be the wall of the uterus, and this would be the cervix, and the fetal head would be right here bulging into the cervical canal. The neck is here. The shoulders are there. The surgeon's fingers are coming right over the shoulders like that with a finger on either

shoulder, the neck in between. The base of the skull is right there. The surgeon would actually, by pressing down, would actually be seeing the base of the skull. He's got his finger on either side.

THE COURT: There is a canal on either side of the fingers?

THE WITNESS: The neck is between the fingers.

THE COURT: All right. Go ahead.

THE WITNESS: If you envision somebody with their hand on your back, a finger on either shoulder pulling down, and so an instrument is guided right between those two fingers into the base of the skull.

THE COURT: As you describe that, do you see that [p. 91] procedure as particularly risky to the maternal health?

THE WITNESS: No. No.

THE COURT: All right. Thank you very much. Let's have that marked as Court's Exhibit number 1, please. I'll have the courtroom deputy do that. I may have raised questions in the minds of counsel. First for the plaintiff.

MR. HELLER: No, Your Honor.

THE COURT: For the defendant?

RECROSS-EXAMINATION

BY MR. SMITH:

Q Dr. Stubblefield, the procedure you have just described with that diagram, have you ever done that yourself?

A No, I have not.

Q Have you ever seen anyone else perform it?

A No, I've not.

MR. SMITH: Nothing further.

THE COURT: Thank you, Doctor. You may step down. For the purposes of clarifying the doctor's questions or answers to my questions, I would like to receive into evidence Court's Exhibit 1 which is the drawing.

MR. SMITH: And just so I can understand, if it's received solely for the purpose of explaining his testimony, I have no objection for it being received for that purpose. If it's received for the purpose that it actually does show that it's a safer or it's a safe procedure, that I would [p. 92] object to.

THE COURT: Well, I simply want it in the record to describe what he told me.

MR. SMITH: On that basis, I have to [sic] objection.

MR. HELLER: No objection, Your Honor.

THE COURT: It's received. Counsel?

MR. HELLER: Plaintiff has no further witnesses, Your Honor.

THE COURT: Let me make clear, are you both agreed, or are both sides agreed that I'm receiving into evidence for purposes of the trial all of the testimony that was previously received into evidence?

MR. HELLER: Yes, Your Honor.

MR. SMITH: Yes, Your Honor, and so it's clear, there was a stipulation that went in conjunction with the exhibits at the preliminary hearing, and both parties are understanding that stipulation also applies because some of the exhibits at the preliminary injunction were received for a limited purpose pursuant to that stipulation.

MR. HELLER: That's correct, Your Honor.

THE COURT: All right. With that understanding, then, plaintiff rests?

MR. HELLER: That's correct, Your Honor.

THE COURT: Thank you. Counsel?

MR. SMITH: Your Honor, the evidence that we would [p. 93] have presented for our medical expert has already been received in the form of a deposition of a medical expert, Dr. Frank Boehm and also a videotape of his testimony. I know that the Court will review the deposition and the videotape and in making its decision with that understanding, we'll rest at this point.

THE COURT: As I told you at our pretrial conference, I'm happy to sit here and watch the videotape with you, if you would like me to, as I tell everybody, I do read depositions, I do watch videotapes in the privacy of my chambers. I'm happy to do that. It saves you all time

and money, but if you want me to watch it here in front of you, I'm happy to. My understanding is neither side has requested that.

MR. SMITH: I don't think that's necessary, Your Honor.

THE COURT: Nor do I.

MR. SMITH: And I think in view of judicial economy and time and expense, I don't see any point doing that.

THE COURT: I'm very appreciative of that. Thank you, counsel. Any rebuttal?

MR. HELLER: No, Your Honor.

THE COURT: All right. You're going to submit your briefs, and I think those will all – Really, the only question I want to readdress to plaintiff, we have one [p. 94] plaintiff here, and if your challenge is facial and it goes beyond previability, do you have standing.

MR. HELLER: Your Honor, just briefly to address the Court's question which we hope to address more fully in our briefs.

THE COURT: Right.

MR. HELLER: I believe, or we believe in general, courts have examined abortion statutes. Whether they were challenged by an individual doctor or by a larger group of abortion or women seeking abortions, once there is a finding the statute violates the Constitution, the statute is enjoined on its face because anyone likely in the future to be affected by the same statute would raise identical legal and factual claims.

THE COURT: See, I'm not sure that assumption is fair here. Dr. Carhart was very careful to tell me that, as is Dr. Stubblefield, their experience with regard to previability abortions, the Haskell D & X, if you are asking me to judge that in the abstract after the fetus becomes viable, that seems to me to be a much more – Well, seems to me to pose very different questions. The mortality risks become different, and I don't have a plaintiff here who has an incentive to litigate that.

MR. HELLER: Absolutely, Your Honor. We have – Let me try to be a little bit clearer about what I'm trying [p. 95] to say. Our primary concern remains that our client be protected from prosecution under the statute.

THE COURT: Right.

MR. HELLER: However, I think there are, the Court can, for example, can enjoin a statute in part.

THE COURT: Right.

MR. HELLER: In certain applications and not others. My concern about addressing this now is that, for example, the Sixth Circuit recently in the *Voinovich* case looked at a differently worded statute prohibiting D & X abortions and looked at it first in terms of its applications prior to viability, and then instead of actually analyzing the substantive constitutionality of the statute post-viability, instead made a determination that it could not take a statute which appeared on its face to apply throughout pregnancy and narrow it to a post-viability statute, that it had to take the statute as it found it and could not – So I think their concern is more about severability or scope of injunction.

THE COURT: All right. All I'm telling you is, you really do need to be very careful to spend some time on this, and with regard to that, I'm not sure that's correct because one of the questions I have got to ask myself is, does Dr. Carhart have an incentive to provide me with information regarding post-viability abortions? and if he doesn't, and [p. 96] the state has had no opportunity to respond to it because he's not presented any evidence, do I have a live case or controversy, really, about that?

MR. HELLER: Absolutely, Your Honor, and I think one of the things we want to address in our brief is certainly, what period in pregnancy does Dr. Carhart – does our client have standing to challenge the statute as to. Nevertheless, that's, I think, different from the question of whether the Court would make, let's say, a holding that enjoins the statute as applied only to Dr. Carhart before viability, or a holding that the statute, based on the evidence presented, is unconstitutional prior to viability, essentially a declaration of that so that if another doctor moved into Nebraska who wanted to do prohibited procedure at 18 weeks, that doctor would not then have to come into court again and repeat a trial like this in order to get protection.

THE COURT: But as a practical matter, Justice Scalia said that it's not only – if Dr. Carhart wins, it's not only for him even under the – as applied. It's for people who are similarly situated.

MR. HELLER: And with that understanding, Your Honor I think –

THE COURT: I mean, isn't that what Scalia said?

MR. HELLER: I'm not sure. Which case?

[p. 97] THE COURT: In the *Guam* case.

MR. HELLER: In his dissent in the *Guam* –

THE COURT: Yeah.

MR. HELLER: Yeah, I think Justice Scalia was talking about that to some extent, but with that understanding, I think the Court and us, we may have a different conception what as applied means in this context. We may be talking about the same thing, but if, for example, if the Court says as to previability abortions, the statute is unconstitutional, it enjoins its application to Dr. Carhart, that will, in all likelihood, protect any future provider who is similarly situated. I agree with that Court about that, and we certainly intend to address these issues very clearly and in detail in our post-trial brief to the Court.

THE COURT: Okay. I think the analysis becomes quite different if this is a facial – may – Let me say may become quite different.

MR. HELLER: Clearly, there is a lot of dispute in federal courts among the circuits about what standard applies to facial challenge to an abortion statute.

THE COURT: Right.

MR. HELLER: We believe the Eighth Circuit has ruled on that in a definitive way. Nevertheless, the Court would certainly avoid some thorny issues.

[p. 98] THE COURT: I'm told it really doesn't make any difference what I do, it's going up, so – But if I can avoid a whole lot of work, if it doesn't make any difference, then I would like to avoid that.

MR. HELLER: And we will certainly consider that in formulating our statement of what relief we seek.

THE COURT: Earlier, I had indicated that the practical effect of holding a statute unconstitutional as applied is to prevent its future application in a similar context but not render it utterly inoperative. To achieve the latter result, the plaintiff must succeed in challenging the statute on its face according to Justice Scalia. And I indicated that as long as he, meaning Dr. Carhart, limits his challenge to how the law is applied to his situation, a favorable ruling for Carhart will not invalidate the Nebraska law generally. Such a ruling would only preclude enforcement of the Nebraska law against Carhart and his patients and other similarly situated doctors and their patients. That's what I understand as applied means.

MR. HELLER: Thank you, Your Honor. It will help us in having your understanding in determining what relief we are seeking.

THE COURT: That's at 920 – 972 F.Supp, I think it's 522 or 523. Now, you know, I just may be wrong, but the prudential concern about – as applied and facial, there is [p. 99] no – if we have – if we have Dr. A who does the same thing as Dr. Carhart, and I would happen to hold for Dr. Carhart in this situation, there is no prudential concern that would suggest that Dr. A would

have to relitigate this. I understood the prudential concern to be that the facial challenge takes you beyond a circumstance in which you have evidence presented to you by an active litigant and provides and may provide to you a situation in which you have to test the statute against an abstract set of facts.

MR. HELLER: Absolutely, Your Honor. We may be very much talking about the same thing. What I might describe as a ruling that the statute is invalid on its face prior to viability may be the same as what, in somewhat different words, what the Court is describing as a ruling that the statute is invalid as applied to abortions prior to viability. When I have used the term as applied, the way I have been using that is more in the sense of as applied to a particular individual, but given the Court's understanding as expressed in the preliminary injunction, that the meaning of as applied challenge with Dr. Carhart as the plaintiff, I think that will affect, certainly, the relief we seek.

THE COURT: Well, that's tentatively what I think as applied means. If you or somebody like you comes before the Court and there has been – If I make a ruling for Dr. Carhart and somebody comes before the Court who is like Dr. [p. 100] Carhart, then that injunction that I would issue would apply to Dr. Carhart and others like him.

MR. HELLER: Again, Your Honor, I just want to – The reason we want to, I think, hold this issue for our brief is that if, for example, the *Guam* dissent, Justice Scalia, I think, pointed out that the *Guam* statute which banned most abortions but had exceptions for the

woman's life and for certain threats to the woman's health, that that statute might be constitutional as applied after viability. Nevertheless, in that case, the federal district court as well as the Ninth Circuit struck the statute on its face.

THE COURT: Right.

MR. HELLER: I think we need to at least examine and present to the Court what appears to be the differing options with respect to that and what relief be [sic] seek, in the sense that Justice Scalia's view appears to be [sic] a dissenting view, although it may identify some prudential concerns that the Court should be rightly aware of in framing its relief. I'm not sure if I'm being very clear.

THE COURT: When we get into facial challenges, the question, I think, becomes whether there is any circumstance in which the law could be constitutional. I think that may be the test, and if there is, you lose.

MR. HELLER: I understand that. Certainly, under that test, it's virtually impossible to prevail on any facial [p. 101] challenge. It's our view, however, that the Eighth Circuit, at least, has rejected that test in the *Planned Parenthood vs. Miller* decision from, I think, about two years ago, although we recognize the Supreme Court has not definitively rejected that, so we also recognize that this Court, to avoid that issue –

THE COURT: I have got to do a multi-part analysis maybe.

MR. HELLER: Possibly.

THE COURT: And if it doesn't matter what I do anyway, then save me from that effort, would you?

MR. HELLER: We are going to really, Your Honor, we will seriously consider the relief we are going to ask for, and we are, you know, I don't want to, without talking to my client further about this, commit ourselves to one way or another, but certainly, our interest is in judicial economy and reducing the need for unnecessary rulings.

I just want to add one more legal issue that arises. One problem, I think, that comes from another body of cases having to do with this question of facial versus as applied is the problem that arises when a court essentially limits applications of the statute, because in doing so, the court may create in essence a new statute that perhaps is better left to a legislature to create in the sense that, for example, if this Court were to facially validate the statute [p. 102] the Nebraska legislature would certainly have the option of enacting a new statute saying we are banning partial-birth abortions after viability, so I just mention that as a competing prudential concern.

THE COURT: You don't want me to construe the statute in a way to limit its reach?

MR. HELLER: In a way that the Nebraska Legislature itself might not want to limit its reach. So that's a competing federalism or prudential concern that I think we need to at least possibly brief to the Court.

THE COURT: Of course, the defendant says that one ought to do that if one can construe the statute in a way to make it constitutional, one ought to do that.

MR. HELLER: There is that general principle. However, on the other hand, our review of the floor debates on this bill make it very clear that the chief sponsor and proponents of the bill, they repeatedly indicated that the statute was not to be limited to post-viability, and I think that's pretty strong evidence that even the Nebraska Supreme Court that was looking at this would say this statute wasn't meant to do that. Now, that's a separate question of whether it actually conflicts with the legislative intent to limit it that way.

THE COURT: Thank you. Counsel, do you wish to add anything?

[p. 103] MR. SMITH: No. It's clearly a matter of briefing it. I don't think there would be anything we could add to it at this point.

THE COURT: Do you have a preference one way or the other about as applied versus facial?

MR. SMITH: Frankly, my preference, after listening to the debate, is to do the research and respond at that time. I think it would be difficult for us to state right now.

THE COURT: Well, give some thought to it.

MR. SMITH: Oh, sure.

THE COURT: It not only affects the plaintiff, but it affects you either way I go in this case. Seems to me I ought to be as clear as I can, and if I were to hold for the State in this case and have to go through a multi-tier analysis, this is what the analysis would be if we forget *Miller* and this is what the analysis would be if you apply *Miller*, and you can avoid all that if you agree and they

agree that it's applied and what applied means. Then it seems to me for everybody, it's clearer. All right. I will issue a briefing order. Once again, my compliments to counsel. You've been very pleasant to deal with in this otherwise hotly contested matter. I appreciate counsels' civility one to the other and to the Court. There being nothing further, we stand in recess.

[p. 104] (Recess at 12:04 p.m.)

CERTIFICATE

I, David C. Francis, certify that the foregoing is an accurate transcription of the record of proceedings made in the above-entitled matter.

/s/ David C. Francis DATE: March 25, 1998
Official Court Reporter

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 3

TRANSCRIPT PREPARED BY THE
CLERK OF THE LEGISLATURE
Transcriber's Office

April 11, 1997

LB 23, 167, 217

* * *

[p. 3959] SENATOR MAURSTAD: That's correct, Mr. Speaker. Senator Brashear was not able to be with us this morning for a variety of reasons, and in discussion with the Vice Chairman of the committee and Senator Brashear, a decision was made for me to handle the committee amendments. I know that Senator Brashear would like to be here and looks forward to being involved in the deliberation of LB 23. The committee amendment combines aspects of Legislative Bills 167 and 217, which were indefinitely postponed by the committee, with LB 23. It amends the definition of "partial-birth abortion", adds a provision providing that no woman upon . . . a partial-birth abortion is performed, shall be prosecuted under the bill, amends Section 71-148 relating to loss of licensure to practice medicine, to harmonize with other provisions of this bill, and adds the emergency clause. The definition of a "partial-birth abortion" is amended in accordance with the definition used in the federal bill. It differs from the federal bill only in that "unborn child" is used in place of "fetus". The green copy of LB 23 says "partial-birth abortion means an abortion

procedure in which the person performing the abortion partially vaginally delivers a living child before killing the partially-born child." The committee amendment changes that to "partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child." The change to "unborn child" was made to harmonize this new section with all other Nebraska abortion statutes, all of which consistently use [p. 3960] the term "unborn child" to refer to the baby prior to birth. The federal bill as passed by the U.S. House uses "fetus" in both places, although the Judiciary Committee version used "fetus" in the first instance, "infant" in the second instance, and then provided a definition that stated the terms "fetus" and "infant" are interchangeable. The second change adds a section that was in one of the other bills that no woman upon whom an unlawful partial-birth abortion is performed shall be prosecuted, and under this section . . . under this section or for conspiracy to violate this section. The third change harmonizes the provisions of LB 23 that that provision for a suspension and revocation of the medical license of a physician who performs an unlawful partial-birth abortion, a provision is added to Section 71-148 as to the definition of "unprofessional conduct" that can result in the loss of the license. The final change is that the emergency clause has been added to the bill. Mr. Speaker, that's an explanation of the committee amendments as advanced from the committee. And once again, I would like to invite good discussion, good debate, good deliberation on LB 23. I look forward to trying to answer, along with others on the floor that have a definite interest in

this bill and have always had an interest in this bill, any questions that come about. Look to effectively address the amendments that may come before us, and continue to work towards the passage of the bill. With that, I'll end the opening on the committee amendments.

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TRANSCRIPT PREPARED BY THE
CLERK OF THE LEGISLATURE
Transcriber's Office

May 12, 1997

LB 23

* * *

[p. 6378] SENATOR BROWN: Mr. President, members of the Legislature, this amendment would add language which appears in model language authored by the National Right to Life Committee to LB 23. I have passed around a copy of an excerpted November 22, 1996, National Right to Life Committee mailing that includes this particular language. The amendment would add a necessary exception to the proposed ban. On page 3, line 21, and on page 6, line 13, after "injury" it would insert "including a life-endangering condition caused by or arising from the pregnancy itself". LB 23, as proposed, provides that the banned procedure cannot be performed unless a woman's life is endangered by a physical disorder, a physical illness, or a physical injury. In attempting to determine whether all the potential problems that could arise in a pregnancy were covered by these three areas, physical disorder, physical illness, and physical injury, I spent a lot of time with dictionaries and I learned that I appreciate abridged dictionaries much more than I

did before. The conclusion, though, is that a pregnancy is not a physical disorder, it's not a physical illness, nor is it a physical injury. A pregnancy can exacerbate several medical conditions, and sometimes the pregnancy itself can endanger the life of the woman. I then. . . . After I looked for the definitions of "disorder", "illness", and "injury", to see if that covered all the areas that could be a potential problem, [p. 6379] there was not, consistency among the dictionaries about the definition of "disorder", "illness", or "injury", other than "illness" was defined as sickness, and "sickness" was defined as illness. There was some consistency among the three states in terms of the use of the word "abnormal". It was recurring several times, abnormal. And I think it's clear, from then moving on to the description of "pregnancy", that pregnancy is not necessarily an abnormal condition. In fact, both the dictionaries and medical authorities that I contacted described pregnancy as a condition, not as any sort of illness, disorder, or injury. In fact, the EEOC has an interpretation on pregnancy that is for the purposes of the Americans With Disability Act, which explicitly excludes pregnancy, because it is not the result of a physiological disorder. So I believe this amendment is necessary to make it clear that life-endangering conditions caused by or arising from pregnancy are included within the exceptions to the prohibition. After looking at regular medical dictionaries and not feeling that I was . . . felt comfortable that disorder, illness, or injury and pregnancy, that I had definitions that felt comfortable to me, I moved on to a medical dictionary, the *Stedman's Medical Dictionary*, to examine the medical definitions of the three areas and pregnancy. And I would like to share

with you the *Stedman's Medical Dictionary* descriptions of "disorder", "illness", and "injury". "Illness" is defined as sickness or disease. "Disorder" is defined as a disturbance of function, structure, or both, resulting from a genetic or embryological failure in development, or from exogenous factors, such as poison, trauma, or disease. "Injury" is defined as the damage or would of exogenous trauma. So in both those cases we are talking about exogenous, outside the body situations, whereas pregnancy, obviously, is an internal situation. Then I looked at the kinds of situations that could be life-endangering because of pregnancy. And in most cases those are things that are exacerbations of existing conditions, exacerbation of heart disease, of hypertension, kidney disease, diabetes, sickle-cell anemia, vascular collagen diseases, and those are all, I think, fairly, certainly illness. The very vagueness of the word may be . . . may make it easier to define those things within that category. There are certain things, though, that are not as clear. Conditions such as toxemia, which is defined as an ill-defined term referring to metabolic aspects of pregnancy, characterized by hypertension, edema, [p. 6380] albuminuria. And so it's not clearly . . . it's not as clear that that is an illness, it is a combination of things. Also, choriocarcinoma, which is carcinoma of the placenta. And the placenta is described as a temporary organ of . . . that develops during pregnancy to nourish the fetus and carry away waste, a temporary organ. And so it's not as clear that that is something that is covered. But the area that I'm most concerned about are those things that constitute emergency situations, hemorragic conditions, such as placenta abruptio, thrombocytopenia purpura, which is a very rare

but deadly clotting disease which is related directly to pregnancy. Some doctors believe that this can be managed through steroids, but it is a very deadly disease that has killed a Nebraska woman within the last year. These are the situations that I think we really need to make sure that . . . they're the ones that probably the exception is the most necessary for, and we really need to make sure that they are included. But it was never my intention to have this amendment be some sort of chicanery that circumvented the ban, and there have been some allegations to that extent. And so in that regard, I would like to ask unanimous consent to withdraw the amendment and substitute.

SPEAKER WITHEM: Senator Brown has requested that this current amendment be withdrawn and that she be allowed to substitute a new amendment. Is there any objection? It is so ordered.

SENATOR BROWN: The new amendment just adds . . .

SPEAKER WITHEM: This is a new amendment. Mr. Clerk, you wanted to reference the amendment for us.

CLERK: Senator, FA249, was the one?

SENATOR BROWN: Yes.

CLERK: Right. (See page 1898 of the Legislative Journal.)

SPEAKER WITHEM: Senator Brown, you are now recognized to open on your amendment.

SENATOR BROWN: This amendment simply adds the word "physical condition" to the previous amendment. So it says, "including a [p. 6381] life-endangering physical condition caused by or arising from the pregnancy itself". As I said, it was never my intention to have it be anything but. We are going to have an opportunity to talk about other kinds of health exceptions. This was, in my mind, always a physical situation. Pregnancy, to me, is a physical situation, life-threatening is a physical situation. And I think that just to make that clarification, and language is important, it was important to add the word. And we can go on and talk about more expansive kinds of health issues on some later amendments, I think, that are going to be offered. But I am very serious about this amendment. I do think it's an important consideration. I hope that we will have a discussion on the merits of the amendment and not just on the bill itself, but on the merits of this amendment, because I do think that it is an important area. The ban that we are talking about in this bill, it's a very difficult, virtually maybe impossible to defend procedure. But it is in these emergency situations where time is of the essence, that I think that the procedure may be justifiable. And so I would ask you to seriously consider those very immediate kinds of life-threatening situations and whether we have clearly enough, in the language that is currently in the bill, addressed those areas. Thank you.

SPEAKER WITHEM: Thank you. We are now discussing the substituted Brown amendment. Senator Landis.

SENATOR LANDIS: Thank you, Mr. Speaker, members of the Legislature. I support the Brown amendment. It has to do with what I think is the underlying purpose. Senator Maurstad introduced the bill and said there was an exception for the life of a mother. Generally speaking, we have statutes on this subject that talk about the life of the mother. They've never used the kind of language which we have in LB 23. LB 23 is the first time that we have the life of the mother exception narrowed down or limited, in which its unclear whether the life of the mother is protected.

* * *

[p. 6389] SENATOR LANDIS: Thank you, Mr. Speaker, members of the Legislature. This is the very first time we've ever limited the life exception in abortion. We've never done this before. We've got it several other places in the statute, it's very clear, but this is the first time we have tried to limit or, in this case Senator Maurstad is limiting the life of the mother exception with this kind of language. Doesn't appear anyplace else. Senator Crosby mistakens the Brown amendment's place in the bill. Understand, this is only when the life of the mother is in jeopardy, this is not for any other justification, this is not an expansion of anything else, except when is it that the mother's life could be in danger. So this has nothing to do with broader and longer lists of exceptions. And the fear that's commonly there, for example, when you use the word "health", there, for example, pro-life supporters say, look, if you use health, that could be mental, that could be wide open, you could manipulate that. This is limited to one and only one

circumstance, and that's where a mother's life is in danger. We have never attempted to shackle that phrase with some, as Senator Maurstad says it's explaining material, but I listened [p. 6390] to that explanation, and if you thought that was a clear explanation, I bet you don't want to be in an emergency room having to solve these problems on a moment's notice with a felony at the ready, because that was clear as mud, as far as I'm concerned. What does the statute normally say? Well, if you've got your statute book, take a look at it, 28-329, existing law. No abortion shall be performed after the time in which, in the sound medical judgment of the attending physician, the unborn child clearly appears to have reached viability, except when necessary to preserve the life of the mother, period, boom, that's it. Now there's also the word "health", but we know that's a different issue. Okay? It says, necessary to preserve the life of the mother. It doesn't define it, it doesn't limit it, it doesn't put three special terms on it, it doesn't turn down what the National Right to Life movement has said is appropriate language, even when it was trying to explain. It said the right of the life of the mother is paramount enough. If that's threatened, you can use this procedure. Senator Maurstad, for the first time in Nebraska law says, that's not good enough, an exception for life isn't good enough, it has to be only one of these three threats to the life; if it's outside that list of threats, well, too bad, she doesn't get her life preserved, she doesn't get to use this practice, she dies. If I'm not satisfied, and by the way, I think, said Senator Maurstad, I think everything is on the list, I don't know, in fact I'm not sure whether pregnancy is or not. I guess it isn't an injury. I guess it isn't . . . it might be an

illness, he says, don't know for sure, but maybe it is. Are we going to allow this bill to pass in a maybe form as to whether the life of the mother is protected? This is good enough? We have, on more than one occasion, protected the life of the mother elsewhere, we have never attempted to put limitations on it, to try to explain it or clarify it, because, you know what, we said, we said it's the life of the mother, that's clear, that's clear, and it doesn't need any more. And it certainly doesn't need to be limited, as Senator Maurstad has done in this bill. Unfortunately, you can't understand the argument easily unless you actually open up LB 23, . . .

SPEAKER WITHEM: One minute.

SENATOR LANDIS: . . . if you don't actually look at the language, [p. 6391] because you'd think that the life of the mother is protected completely, but it's not. You can see it in Section . . . lines 8 through 18, through 22, page 3, Section 3, no partial-birth abortion shall be performed in this state unless such procedure is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury. Senator Maurstad isn't clear, where a pregnancy is in that. And, by the way, women die of pregnancies. Women who want to have children, who are in the birthing process because they want to be there, and the head of the child is too much of a trauma, and hemorrhaging begins, and the actual process that the mother wants to have to go forward can prove to be lethal.

SPEAKER WITHEM: Time. Senator Maurstad.

SENATOR MAURSTAD: Thank you, Mr. Speaker. As I indicated before, you have to look beyond

just this particular section when you're looking at what the issues that Senator Landis and Senator Brown raise. The description that he was just . . . and the example he was just going to use is not a situation where a partial-birth abortion was taking place. There has to be the intentional and knowing performance of a partial . . . an unlawful partial-birth abortion. Now, as I indicated before, and I'll try to speak for myself so someone doesn't have to explain what I'm trying to say, I hope that you will listen to what I have to say and use your own interpretation of what I have to say. This doesn't, as I indicated before, pose a real problem to the bill, as I indicated before. In fact, I think it has validity, had validity before. I indicated if the members want to include it, that's fine. I'll even go so far as to say, so that we can move on to the issues dealing with the health exception, I'll vote to adopt the Brown amendment. I'll recommend that we adopt the Brown amendment. National Right to Life doesn't have a problem with the Brown amendment. She's made the amendment more palatable, I agree. I don't know that it was particularly necessary that the word "physical" be included, but she's gone that extra step to do so. And so in good faith, I'll accept that and recommend that we go to a vote on the Brown amendment. I'm going to vote for it, we'll see if there's enough support among my colleagues to do that, then we can move on to the health exception, for which there is no explanation as far as I'm concerned at this point. So, with that, Mr. President, I'll [p. 6392] relinquish the balance of my time.

SPEAKER WITHEM: Senator Hillman.

SENATOR HILLMAN: Yes, Mr. Speaker, members. I think probably one of my concerns and why I'll support the Brown amendment is to be able to understand the situation that you have between the physician and the patient, and that we don't . . . aren't so restrictive in the language that we somehow interfere with that process, because the physician will be concerned about liability issues or that we have narrowed the definition when it comes to saving the life of the mother. In visiting with gynecologists that I have in my area, and we have a fine wellness clinic there that works very well with women, that has had an ongoing relationship, and they're not concerned particularly about this bill, other than they feel that the process . . . or that they've had . . . that they know their patients, that they've been able to work with them, they just want to make sure that there's nothing that's going to interfere with their decision-making process and the way that they can deal with women on a confidential basis. The other thing that I would like to mention relates somewhat to Senator Vrtiska's comments that there seems to be some type of, I'm going to call it a stereotyping, that if you discuss abortion related bills that you're automatically pro-abortion. And I guess I take exception to that. I think we need to look very carefully at any legislation that comes up that, addresses legality of abortions and how they are handled in the state. And one of the reasons I ask a lot of questions or try to understand the legislation that's being introduced is that I have always come down on the side of looking at what it means to have a choice for people to have some control over what their actions are. It does not mean that you are pro-abortion, it means that there are situations that you

want to see that can happen that, in the cases of abortion, that people do have a choice, it doesn't mean that you support abortion. And to automatically be labeled as pro-abortion is something that you're promoting or suggesting that you think it's a good method or it's something you would advocate for people to do, I take somewhat an exception to. It's. . . . I think we've asked questions on and tried to improve all legislation that comes in front of this body. And I think it most certainly behooves us on legislation that's abortion related that we ask those same [p. 6393] questions and see that we do protect the rights of . . . legal rights of women in the state of Nebraska, and so we question that legislation very carefully. It does not necessarily mean that we are "pro-abortion". And how much time do I have left, Mr. Speaker?

SPEAKER WITHEM: You have two minutes.

SENATOR HILLMAN: And, Senator Landis, if you would like to [sic] rest of my time, I'd be glad to yield it to you, otherwise I'll give it back to the Chair.

SPEAKER WITHEM: Senator Landis.

SENATOR LANDIS: I heard Senator Maurstad's speech and I was . . . I thought that was a helpful suggestion for our debate. What I'm unclear of is whether or not Senator Maurstad is in a position to accept the amendment as he just said he would and vote for it, which I think is a good idea and would allow us to move on, if, in fact, the rest of his colleagues who are signed onto the bill don't go along with it, we'll have to go back and revisit this issue. I'm hopeful that the body heard Senator Maurstad say he'd accept the amendment. And, if that's the case, my light is on and when that light

comes on I'd move to call the question and permit us to vote on the issue and move on, in the event the body is sufficiently well informed and agrees with . . .

SPEAKER WITHEM: One minute.

SENATOR LANDIS: . . . Senator Maurstad that this amendment should be adopted.

SPEAKER WITHEM: Senator Brown.

SENATOR BROWN: Mr. President, members of the Legislature, I feel the need to respond to a couple of the statements. Had it been my intention to broaden or to weaken the language of the bill, I'm not sure why I have used language directly from the National Right to Life Committee to do that. I'm not sure why they would have advocated this language in their model legislation. I think that there are very rare, and I admit that they are very rare, circumstances, emergency, immediate [p. 6394] situations. And I chose to believe the sponsors of this bill that they really intended to protect the life of the mother. And if there is any circumstance where this procedure, which is virtually indefensible, as I said before, where it is justifiable, it is in these very rare emergency situations, very immediate, and that is when I think we really need to make sure that we are protecting that woman, when she may not even be able to be a part of making the decision herself. Thank you.

* * *

[p. 6398] SENATOR LANDIS: Thank you, Mr. Speaker, members of the Legislature. This is both in your computer, and it's on your desk. We are talking about the health of the . . . I'm sorry, not the health, the life of the

mother exception. Because we are on a path that we've never charted before, which is limiting the health . . . I'm sorry, limiting the life exception for the mother. We have an interesting phrase here, understand this is only where the life of the mother is in danger. Senator Maurstad says, you know, under the circumstances there are . . . this partial-birth abortion should be allowed, and there are two sets of conditions. One, you have to be inside the physical disorder, physical illness, physical injury, and now the physical affects [sic] of pregnancy, one of those four limiting conditions. And in addition to being in that limited set of conditions, you also have existing law in this bill that says, and no other medical procedure would suffice for that purpose, no other medical procedure would suffice for saving the life of the mother. Now, the difficulty here is that since we've never limited the life exception for the mother before, except now in LB 23, we've never had to worry about what this kind of a phrase means. We've always said, look, the health of the life of the mother is the trump card, the life of the mother is the trump card, consistent with Catholic doctrine, and consistent with the ethical standards of the medical profession, it's consistent with the principle of self-determination, the life of the mother needs no definition, explanation, clarification, or certainly limitation. So we've never had a phrase like this before. And no other medical procedure would suffice for that purpose. Well, there are multiple procedures. What if a procedure that, if it's successful would suffice, is also risky? What if it [p. 6399] would suffice, but only in 30 percent of the cases? What if there's . . . what if this outlawed procedure would be . . . would be successful in saving the life of the mother

more often than that procedure, but that procedure, if it was successful, would be sufficient? What's the law say? It's not clear. Senator Maurstad's never made this clear, and my guess is he's going to turn his light on and tell us what he thinks this means. But since we've never limited the life exception before, and we've never had a phrase like this, no other medical procedure would suffice for that purpose, would suffice for that [sic] purpose. What isn't clear to me is that you get to use the safest method possible, whatever it is, including this partial-birth abortion. If that's the safest method, or as safe as any other and any other procedure runs the same amount of danger or more danger, you get to use this procedure. Senator Maurstad doesn't make it clear. He says, would suffice for that purpose. Here's what I say, strike "no other medical procedure would suffice for that purpose", which is this, you know, loosey-goosey, unclear language, and says, "any other procedure would pose equal or greater medical risk". So, the phrase would read this, and, by the way, remember, we're talking about the life of the mother, and no partial-birth abortion shall be performed in this state, unless the procedure is necessary to save the life of the mother, the life exception. And now we start these limitations, whose life is endangered by a physical disorder, physical illness, or physical injury, plus the Brown amendment, and any other procedure would pose equal or greater medical risk. Medical risk to who? To the mother, to her life. So we're still using this limited definition. We're still keeping the limits, but we're replacing what I think is language that you can't be clear about, no other medical procedure would suffice for that purpose, and substituting with a standard that I think we can

understand better, "and any other procedure would pose equal or greater medical risk", "equal or greater medical risk". Understand, this doesn't undo the fact that you have to mean the life of the mother, that has to be at risk, and it has to be at risk because of the . . . one of the four factors that it describes. Okay? We're down to very limited numbers. In that case, don't we . . . shouldn't we be free to use the safest procedure to the life of the mother? Isn't that fair that we be free to use what is as safe or safer than any other procedure, including if it happens to be this procedure? Do we have to authorize a less [p. 6400] safe procedure and risk the mother's life at a greater percentage, at a greater risk than using this? We're not talking about adding to the list of reasons beyond the life of the mother, we're not adding to that list. We're talking only where the life of the mother is at risk. And my question to you is, if that's the condition, shouldn't the doctor be able to use the safest procedure, or whatever the procedure is that is equally the most safe, whatever they are, given the conditions and what's best for the mother's well-being at that moment? We're after protecting the mother at this point, right, 'cause we're in the life of the mother exception, so that's the paramount goal. Shouldn't her safety be the paramount goal? And no other medical procedure would suffice for that purpose. What purpose? What purpose? No other medical procedure would suffice. You mean if it might work one in ten, or in that case it could suffice? That's it? Or does it mean the same thing? Are you trying to get at the same thing here? Look, the mother's safety is critical. We want to protect it, we think that's fair, and, look, we're trying to protect her health. If that's the case, why don't you say

it? Why don't you just say, look, where any other procedure would pose equal or greater medical risk? Then you could use this. Why? Because the trump card, the health of the mother is the most critical thing. I don't predict this amendment will be adopted. The fact that we are for the first time putting limitations on the life of the mother exception is disturbing to me. But if we do that, and if you are bent towards that end, it seems to me that you have to account for the safety of the mother. And where procedures are either equally safe as this one, or less safe than this one, this one ought to be free to be chosen so that the life of the mother can be protected. It's the alleged goal of the bill, and the riskiness of the procedure should be able to be counted, should be taken into account. And I can't see, on the face of the language, that it's taken into account. It is not clear that the riskiness of the procedure is accounted for in the language of LB 23. And the life of the mother and the safety of the procedure should matter, they should be important to us, and we should guarantee to a mother whose life is at risk that you get to use any procedure that will save her life, certainly a procedure that proves to be safer . . .

SPEAKER WITHEM: One minute.

[p. 6401] SENATOR LANDIS: . . . than others, or as safe as any other, in which case that procedure ought to be available to save her life.

SPEAKER WITHEM: Senator Chambers.

SENATOR CHAMBERS: Mr. Speaker, obviously I support Senator Landis' amendment. And I will listen to see, if people speak against it, what reason they would give. I hear so many times on this floor people talking

about family values, the sanctity of the family, inappropriate intrusiveness on the part of the government. Then with hobnail boots this Legislature is going to go trundling into the most intimate area of a woman's life. This bill is punitive. There is a hope, it seems, from the way I read the body, a majority of them, that a woman in this situation will forfeit her life. They want this to be a death sentence on a woman for contemplating this procedure. So, if, as Senator Landis' amendment would require, any other procedure would pose equal or greater medical risk, that is rational, if that is rejected, then what I'm saying is true. However, it's sugar-coated, however people try to pretend that they're so concerned about a fetus, this is a hatred toward woman piece of legislation. If they were merely interested in throwing up safeguards and restricting a medical procedure to those circumstances where they genuinely believe it ought to be utilized, they would, first of all, name it correctly, instead of resorting to what I call back alley, tavern, street corner language, which is all right out there, but this demeans the statutes. We don't even honestly say what this is. If it were a business issue, we would say, let the bill say what it means. If it were a tax issue, we would want everything precise and definite and expressed in the language of the tax environment, the tax universe. Here there is so much bitterness, hatred toward and contempt for these women that language is to be perverted, the statutes are to be distorted, medical procedures are to be twisted, tortured, and turned into something as hateful, grotesque, and bizarre as possible. I find the process that is contained in LB 23 to be bizarre and hateful. What business is it of the Legislature? You get the impression that, with all this

concern for fetuses, this Legislature is willing to bend over backwards to make sure that the children in this [p. 6402] world are properly cared for, that if the state can intervene in this situation, it certainly will see a responsibility to spread protective arms around those children who are children in being, not unborn, not potential, but children here among us. Yet I see these pieces of legislation that slash assistance and programs that will help those children grow and mature into healthy human beings. So when there is all this talk about what happens in the birth canal and prior to that, but no concern for . . .

SPEAKER WITHEM: One minute.

SENATOR CHAMBERS: . . . that which emerges from the birth canal, I have names that I apply to that, but I won't do it this morning at this particular point, but I may get around to it before we are through. I'm going to listen again to hear what the objection is to Senator Landis' amendment before I proceed. Having not heard that objection, all I can do is express my support for it and my reason for supporting it.

SPEAKER WITHEM: Senator Maurstad.

SENATOR MAURSTAD: Thank you, Mr. Speaker. This bill is about prohibiting a particular abortion procedure, partial-birth abortion. It is what it is. It defines exactly what we're trying to prohibit in the state of Nebraska. I. . . . Senator Chambers has mischaracterized the bill, has mischaracterized the terminology in the passage that we're discussing with the Landis amendment. This is not a death sentence. This is not demonstrating any hatred or contempt for women, he knows that. This is very clear what we're talking about when we

talk about "no other medical procedure" relative to the exception that now has been expanded on the floor this morning to include any complications that arise out of the pregnancy. I think it's very clear, no other medical procedure, any other procedure, I mean they're just two opposite ways. The Landis terminology is too expansive I believe. The way that the bill is written is easily understood, there's nothing complicated about it. We're talking about the life exception, we've made a provision for that. Quite frankly, there isn't any medical testimony that has been presented so far, to my understanding, that this procedure is the only procedure that is available to save the life of the [p. 6403] mother. In fact, most of the testimony that I've seen, most of the information that I've read is that there's no medical reason for a partial-birth abortion. And I want to again emphasize we're talking about intent, we're talking about an abortion procedure, we're not talking about a regular birth of a child here, so I don't accept the Landis amendment. He's indicated as much in his opening that he didn't expect it to be accepted. I think he's accurately gauged that. I agree with him that I don't believe that this amendment will be adopted. It shouldn't be adopted. We've made it an exception for the life of the mother, we've expanded it this morning for clarification, to make sure that any complication arising out of the pregnancy is now within the scope of this. It's never been discussed because we've never discussed a procedure such as a partial-birth abortion before, never limited it before because we've never looked, at the whole issue of taking a particular procedure at 24-weeks and beyond, and looking at saying, not that way. There's no medical reason that we need to

have partial-birth abortions in the state of Nebraska. There's no medical reason that would indicate that there is a life-threatening circumstance as a result of the abortion itself, so I don't think that this is necessary. I will continue to listen, as I have, see if a case can be made that the language should be changed from "no other medical procedure would suffice". If there is a medical procedure that would be there, be available, the language would allow it, if it's to address a life-endangering circumstance as a result of a physical illness, injury, or disorder. So, I think we're beginning, in my view, of starting to split hairs.

SPEAKER WITHEM: One minute.

SENATOR MAURSTAD: I think it's very clear and I oppose the Landis amendment. I hope that my colleagues will join me in opposing the Landis amendment. As I indicated before, this isn't punitive. We do care about this circumstance about both the mother and the child. So I'll continue to listen to see if there's something that I'm not aware of that would change the course of the discussion on the Landis amendment.

SPEAKER WITHEM: Senator Landis.

[p. 6404] SENATOR LANDIS: Thank you, Mr. Speaker, members of the Legislature. If you got a feel for what's sufficient to . . . what "sufficient" meant out of that speech, you're better than I am. Simply saying it over again, "no other medical procedure will suffice for that purpose" is not definition, it is not clarity, and it is amazing to me that the health of the mother and the insurance that the medical procedure that we use to save that life be itself safe, is regarded as "splitting hairs". The

health of the mother is not splitting hairs. The procedure used to save her life is not hair-splitting. It deserves clarity, and there was no clarity in that speech whatsoever as to what the phrase "would be sufficient" . . . "sufficient for that purpose" means. Let's try again. Senator Maurstad, let me ask you a question, I'll try to do it fairly, I'll try to give you a chance to respond. But I actually want to try a response here. Tell me if there are two procedures, one of them is a partial-birth abortion, one of them is another, it could be prolonged labor, it could be a hysterectomy, it could be a caesarian, there are alternative measures to protect the life of the mother in this situation. Does your language say that the doctor is free to choose any of those procedures if those procedures . . . a procedure from among that list is necessary to save her life? If there's an . . . . I hope I've made the question clear, but I'll try again if it's not clear.

SENATOR MAURSTAD: No, it is unclear. Could you ask that question again . . .

SENATOR LANDIS: I'll try again. If there are two . . .

SENATOR MAURSTAD: . . . (inaudible).

SENATOR LANDIS: If there are two potential procedures, one of them a partial-birth abortion, one another one, a vertical caesarian, both might be tried to save the life of the mother. Is the doctor free to use the partial-birth abortion when another procedure exists?

SENATOR MAURSTAD: Yes. It says, "and no other medical procedure would suffice for that". You've indicated that no other medical procedure would.

[p. 6405] SENATOR LANDIS: No, in fact, I've said that there are two, there are two procedures, a partial-birth abortion and let's say a caesarian. In that case you couldn't use the partial-birth abortion, you'd have to use the caesarian, wouldn't you?

SENATOR MAURSTAD: Yes.

SENATOR LANDIS: Okay. What if the caesarian is a more dangerous procedure for the life of the mother?

SENATOR MAURSTAD: If it were, it would not be prohibited, but it isn't.

SENATOR LANDIS: If the caesarian was more dangerous, you could use the partial-birth abortion method of saving the life of the mother. Is that what you're telling us?

SENATOR MAURSTAD: Yes.

SENATOR LANDIS: Okay. So, when you use the word "sufficient" in there is this weighing, you got two procedures, if they're the same, don't use this one, use the other one. But if the other procedure is riskier, you would be free to use partial-birth abortion in the pursuit of the saving of the life of the mother. I think I've fairly characterized what you've said, but confirm that for me, if you would, that I've fairly characterized the argument you've just made, the point you just made?

SENATOR MAURSTAD: Senator, I don't know.

SENATOR LANDIS: All right, let me try it again. Here's my characterization of what you just said on the mike. You've got two procedures . . .

SPEAKER WITHEM: One minute.

SENATOR LANDIS: . . . and one of them is the partial-birth abortion, one of them is another one, a caesarian, prolonged continuation of birthing, whatever. Between these two, if one . . . if the . . . if the partial-birth abortion is less risky, if the other procedure is more risky to the life of the mother, the [p. 6406] doctor will be free to use the partial-birth abortion method to protect the life of the mother.

SENATOR MAURSTAD: Yes.

SENATOR LANDIS: Good, okay. In that case, there really isn't a difference between our points of view because I think that that should be the law as well. That is, the doctor should be able to pick the safest method to protect the life of the mother. Why can't we say that? I happen to agree with what Senator Maurstad just said.

SPEAKER WITHEM: Time.

SENATOR LANDIS: And I think the law ought to say that clearly.

SPEAKER WITHEM: Senator Dierks.

SENATOR DIERKS: Mr. Speaker, pardon me, and members of the Legislature, I just stand in opposition to Senator Landis' amendment. As far as I'm concerned the language of the bill is just the way it should be. I think it's been researched rationally, we've looked at it closely at this stage, there's no reason for us to make any adjustments in the bill, and I would oppose the Landis amendment. Thank you.

SPEAKER WITHEM: Senator Chambers.

SENATOR CHAMBERS: Mr. Speaker and members of the Legislature, as on other pieces of legislation, an outside group connected with the Catholic Church, primarily, is pushing this, Right to Life, they were mentioned here, Senator Maurstad said since their imprimatur was on Senator Brown's amendment, it could be adopted. So this is a particular religion's approach. And that's why some people, such as Senator Dierks had just said, will say there's no need for us to make any adjustments, our work as a Legislature has been done for us by others, and we should just roll over and accept it. Fortunately, and this is one of those that I call . . . those pieces I call trash legislation in every sense of the term, poorly written, pejorative, dishonest, inaccurate. I'm sorry Senator Dierks left, because I've heard him talk about various issues in the Ag Committee, [p. 6407] and I'm sure if we were discussing animals we'd be able to talk more about biological procedures in a more accurate fashion. I'm sure that those people on this floor who make their living in agriculture would not hesitate, if a fetal calf threatened a life of the mother, to get rid of that calf, if it meant cutting off each leg, cutting off the head and anything else, because they know biologically in this process what it takes to preserve the life of the mother. Then they want to pretend that somehow biological processes are different when they involve human beings. We are not equating human beings to four-footed animals, but we're saying, I am saying that the processes are the same. Sperm is sperm is sperm. We even had a bill here some years ago that was going to exempt the sperm of certain bulls from the sales tax. They didn't call it anything other than sperm, and that's what they call the

substance in a human being. But all of a sudden we'll have senators who will say that if you have one of these, and I'm using this terminology for popular consumption, if you have one of these calves that has a lot of water, a lot of fluid in its skull, and that could . . . that would prevent a normal birthing process, the calf is gone by the board, and there is no way that that calf is going to be a functioning creature when it comes out. But there are people on this floor who will say, well, if you have one of these children who is severely deformed or malformed, once you somehow birth it, however you have to do that. I'm surprised they don't have something in this bill that would say when you come to the front part of a woman's pelvis, where the bones join, you don't just take a meat ax and split it, and pry open her pelvis so that the opening is large enough for one of these large skulls to come through. I'm surprised they didn't think to put that in. I wish I hadn't said it, because now they might add that as an amendment, but it would show the true character of this bill and the attitude behind it. Senator Landis' amendment makes an affirmative declaration. Senator Maurstad's amendment, his language which he got from Pro-Life, or Right to Life, whoever they are, declares it in the negative. And again they use street language, meaning just ordinary words that people use, and they're not defined and they have no meaning in the law. But they have to be so careful that they do exactly what . . .

SPEAKER WITHEM: One minute.

[p. 6408] SENATOR CHAMBERS: . . . Pro-Life or Right to Life, whichever one it is, told them to do, that there can be no change in the language, even though those supporting it cannot define it, cannot say what it

means. This is a very serious area. And even though the majority of senators always jump on the bandwagon and do what they can to restrict a woman's right to terminate a pregnancy, I will speak just as strongly for her right to do that. And I don't care if people are offended, I'm far more offended at the cruelty in these bills. Fortunately, legislation of this kind is under attack in other states, and I think it will be struck down by courts. The worse this bill is, the better it is ultimately, the better in terms of the chances of it being struck down. They ought to attach an A bill to all these things, because they always are challenged in court . . .

SPEAKER WITHEM: Time, Senator.

SENATOR CHAMBERS: . . . and generally lose.

SPEAKER WITHEM: Senator Maurstad.

SENATOR MAURSTAD: Thank you, Mr. Speaker. I rise again in opposition to the Landis amendment. Once again want to indicate the purpose of the law to start with. When many of these partial-birth abortions that are taking place right now occur, it's when the child is viable. There are other means in which to take care of the circumstance that's presented by that. What we're looking at is trying to prohibit the use of this unbelievable procedure in the state of Nebraska to abort a child. Now, I want to indicate . . . I was not characterizing the issue of the life or the health of the mother when I made the comment relative to splitting hairs. Senator Landis knows that. I was talking about the difference between the terminology that he uses and the terminology that's in the bill in the way in which you can say something is similar by words. I will try to be as clear as I can. And I

apologize, Mr. Speaker, to the members if I'm not as clear and my clarity is not to the standard of some members. I'm trying my best, as other members try their best, in explaining the provisions of the bill. But when given . . . giving an answer is not accepted and then is . . . just indicated that it's unclear, unwillingness to accept it because [p. 6409] of the unclearness, I apologize for that. I'm trying to be as clear as possible. I think people know what "physical disorder" is, "physical injury" is, "physical illness" is. Now, I can haul out dictionaries and terminology and we can go and talk about what all those things mean. I think people know what they mean. People know what "partial-birth abortion" means. It's when a child is partially delivered. Every part of the child is outside the womb of the mother except for its head. And the head is only kept in there for one reason, and that's to perform the abortion. And that's why it's called a "partial-birth abortion", and we'll probably get into that dialogue a little bit later on a proceeding . . . on an amendment that will be coming forward later, talking about specifically that language. But I would say, again, that I think it's clear . . . I'm not going to stand up here and be redundant, as indicated. I think Senator Dierks probably hit the nail on the head. He likes the way the bill is written now. I like the way the bill is written now, as amended by Senator Brown's amendment that I agreed to that addressed, I think, a need that needed to be addressed. But I think it's very clear that what we're saying is, there's an exception for the life of a mother when were looking at a partial-birth abortion procedure, and the intent of that, and no other medical procedure would suffice, then partial-birth abortion can be used.

When there is another medical procedure that would be . . . that would suffice, you would use that. So I'd ask my colleagues to vote against the Landis amendment.

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[p. 6412] SENATOR CHAMBERS: Senator Maurstad, you and Senator Dierks have talked about how perfect this language is, and Senator Dierks can be at least be considered a quasi-scientist. I'd call him a scientist. Show me in this bill where it says that a partial-birth abortion means that all of the child has been delivered except for the head. I don't see that in the language.

SENATOR MAURSTAD: The language on page 3, and it's cited again later, Senator Chambers, indicates that "partial birth means", and then it goes on, "perform the abortion partially delivers vaginally a living unborn child".

SENATOR CHAMBERS: Where does it say, as you . . . are you willing to admit that the description you gave is not what's in the bill? You said, all is delivered except for the head. That's not in this bill, is it?

SENATOR MAURSTAD: No, it says "partially delivered".

SENATOR CHAMBERS: And that could be a foot.

SENATOR MAURSTAD: That could be a foot.

[p. 6413] SENATOR CHAMBERS: So your statement was inaccurate, and if we look at this language, we don't really know that this means what you said it meant earlier, do we?

SENATOR MAURSTAD: My statement was an accurate explanation of the words in the bill.

SENATOR CHAMBERS: Why don't you write in this bill what it is you mean if you mean everything is outside except for the head? Because Right To Life didn't put that in their model bill, isn't that correct?

SENATOR MAURSTAD: No, Senator Chambers. As . . . I don't believe you were at the hearing where this bill was up, but I . . . at that hearing I indicated that I did not introduce LB 23 on the behalf of any organization.

SENATOR CHAMBERS: Well, I don't care about . . .

SENATOR MAURSTAD: I used . . . well . . .

SENATOR CHAMBERS: I don't care about that.

SENATOR MAURSTAD: But that's . . .

SENATOR CHAMBERS: I want to know where the language came from.

SENATOR MAURSTAD: The language came from the bill that was adopted by both houses of Congress and sent to President Clinton.

SENATOR CHAMBERS: And who . . . where did that language come from?

SENATOR MAURSTAD: I think that language was a compilation of a number of people that were in . . . and groups that were interested in this particular issue.

SENATOR CHAMBERS: I was told . . . I heard earlier this morning about Right To Life supporting the language that Senator Brown put in and the model language that they came up with, and that seems to track pretty much what Congress did. Is that correct?

[p. 6414] SENATOR MAURSTAD: They . . . that amendment indicated what National Right To Life's . . . that they approved that language. It didn't say that they drafted the language.

SENATOR CHAMBERS: Why are you so shaky and unwilling to acknowledge what we all know to be the case?

SENATOR MAURSTAD: I'm not shaky.

SENATOR CHAMBERS: What's wrong with it?

SENATOR MAURSTAD: I'm not shaky at all. I don't think there's a problem at all with people understanding, and that's why I brought it to everyone's attention that National Right To Life supported that particular language. National Right To Life has had involvement in this bill, as has . . .

SENATOR CHAMBERS: And National Right To Life means that everything of the child is outside except for the head, isn't that true?

SENATOR MAURSTAD: No. They would indicate that they would be supportive of the language that's in . . . that a partial-birth abortion is defined as abortion when the child is partially delivered.

SENATOR CHAMBERS: And "partially" means anything. A toe. Is that what Right To Life was concerned about, that the toe of a child might be outside . . .

SENATOR MAURSTAD: National Right . . .

SENATOR CHAMBERS: . . . the birth canal, and that's why they want this legislation?

SENATOR MAURSTAD: National Right To Life is concerned about a viable fetus being aborted by this particular procedure.

SENATOR CHAMBERS: Members . . . thank you, Senator Maurstad. Members of the Legislature, what I want the record to show is that . . . we're not legislating here. This is rubber stamping. [p. 6415] Senator Maurstad knows what he thinks this language means because he knows what the discussion . . .

SENATOR BRASHEAR: One minute.

SENATOR CHAMBERS: . . . has been based on. But the language in the bill does not say that. The definition does not say that. And it does not name the medical procedure involved, so all that a physician would have to do is say, there is nothing known to medicine as what's talked about in this bill. There is a procedure that we use, and that is the procedure which was used, and it has not been made unlawful under Nebraska law. This is a sham and a shell game as all these types of bills are. I'm in support of Senator Landis' amendment.

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[p. 6416] SENATOR LANDIS: Thank you, Mr. Speaker, members of the Legislature. My first source of

concern is that LB 23 . . . it's the first time we've ever put limitations on the right of the mother to protect her own life. We've never done that before. And Senator Witek said that, in fact, those are all existing elsewhere in law, but they are not preserved in this situation. Senator Witek is mistaken in her reading of existing law, because when you get to this situation and the life of the mother is in danger, what LB 23 says, we're going to take off the table the partial-birth abortion method, unless it meets these qualifications. And if her life is going to be lost . . . but these limitation words aren't met . . . well, too darn bad, but this is off the table. The whole goal of the bill is to take partial-birth abortion off the table, and this is the exception area for the life of the mother. The life of the mother in this case, for the first time, is limited, and secondly, it's not only limited by the set of conditions and circumstances, but it's limited if there is another medical procedure which would suffice for the purpose of saving the life. Now, luckily, on [p. 6417] the floor, Senator Maurstad said, look, if the partial-birth abortion method is the safest method, then you can use it to save the life. And that we agree on. Where I think it also should be the case is that if the partial-birth abortion method is as equally safe as any other method, that it should be the doctor and the mother, who will have to live with the consequences of these choices anyway, who should make that choice. And for me, that's a much better description of the words "suffice for that purpose". That's the one that's in the green copy of the bill. Unclear, Senator Maurstad made it clear in his floor speech, but you can't look at the green copy of the bill and know what that means. We now have a clearer description of it, given the

floor debate, and between Senator Maurstad's description on the floor and my amendment and his bill, my amendment is a lot closer to what he said than the green copy of the bill is. I would ask that the introducers say what they mean. Senator Maurstad's done it on the floor. I applaud him for it. The green copy of the bill does not clearly say that. My amendment far more clearly captures what Senator Maurstad said than what's in the green copy of the bill, and I'd just ask you to say, in plain English, what you mean by the bill. That's what this amendment does.

SENATOR BRASHEAR: Thank you, Senator Landis. Members, you have heard the closing. We will proceed to vote on AM2065. All those in favor, please vote aye. Those opposed nay. Have you all voted? Mr. Clerk.

CLERK: 12 ayes, 19 nays, Mr. President, on adoption of the amendment.

SENATOR BRASHEAR: The amendment is lost.

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SENATOR SCHIMEK: Thank you, Mr. President, members of the body. You'll find the amendment on your gadget. I'm having a hard copy passed out, too, but let me tell you verbally what the [p. 6418] amendment does. Again, it addresses the language on page 3 and page 6. On page 3 in line 21 and page 6 on line 13, and after "injury" you would insert . . . and this may have to go actually up to the additional language that we adopted of Senator Brown's . . . but it would say, "or if in the best clinical judgement of the attending physician a

woman's fertility or physical ability to carry future pregnancies to term is at risk." I can't imagine that members of the body would not want to provide for these exceptions. The intent of LB 23 maybe to prohibit the intact D and E abortion procedure. However, the ban could affect other medically necessary procedures not related to abortion. Whether used as an abortion method or for other pregnancy-related medical purposes, it is essential to provide an exception to protect a womans fertility and her ability to carry future pregnancies to term. To help understand the need for this amendment, I provide a scenario that a local OB/GYN presented to me which reveals the complexity of medicine and the dangers inherent in trying to impose blanket bans. And I apologize because I think all of us are somewhat at a loss on this floor because we don't know about some of these different complexities, but a woman who I will call "Jane" is having a spontaneous abortion, or miscarriage, in the second trimester of pregnancy, prior to fetal viability. When Jane arrives at the hospital, the fetus is in the birth canal, partially expelled, feet first, and the head wedged in the cervix. It has a heartbeat. The doctor will try medications and other methods to help Jane complete the miscarriage. However, if the fetus is not expelled after a period of time, major problems can arise that threaten her life and health, her fertility, and her ability to carry future pregnancies. Among the problems that can arise are bleeding. In the second trimester of pregnancy the cervix is firm, hard, and not in any way ready to dilate. If the fetus' head is stuck in the cervix, the uterus is not able to contract. Uterine contractions are necessary to stop bleeding which can threaten Jane's life. Another potential

problem is infection, which can set in very rapidly in these situations. Infection can lead to uterine scarring and adhesions in the fallopian tubes, both of which can make a woman sterile. Adhesions in the fallopian tubes also can lead to ecotopic [sic] or tubal pregnancies, which are always fatal to an embryo and dangerous for a woman. If not diagnosed and treated early, the tube can rupture, threatening a woman's life. Often, [p. 6419] the whole fallopian tube, occasionally with the adjacent ovary, has to be removed. In Jane's situation, the doctor cannot simply use force to pull the fetus from her body. Surgical intervention is necessary to prevent excessive bleeding and infection. The only options are to make the cervix larger or to compress the head of the fetus. Cutting the cervix, however, presents the potential for serious, even deadly, complications. If the doctor tries to cut Jane's cervix to increase its size, there is the risk of cutting into her bladder or rectum. Her cervical branch of uterine arteries would be at risk as well. If these major arteries are cut, Jane would suffer major bleeding and could die in a matter of minutes. Attempts to tie off the arteries and stop the bleeding could damage Jane's ureter and her kidneys. If time allows, the doctor might be able to hurriedly complete a hysterectomy, but then Jane would never again conceive and bear a child. Cutting into the cervix can also damage glands which play a role in a woman's ability to become pregnant. These glands secrete a mucus that helps transfer sperm. If damaged, a woman's fertility is compromised. Another problem with harming the cervix is that Jane could be left with a condition called "incompetent cervix". In this condition, the cervix is too weak to support the increased pressure

of a growing pregnancy, and it is generally not possible for a woman to carry a pregnancy to term. Possible treatments include total bed rest or the surgical closing of the cervix, although this procedure has limitations. An incompetent cervix may not be diagnosed until after a woman suffers a miscarriage or has premature labor and delivery. In Jane's case, suffering a miscarriage of a nonviable fetus the compression of the skull to allow it to pass the cervix is probably the safest option. It would be medically and morally wrong to disallow a procedure that may be the final resort to protect Jane's life, her health, her fertility, and her future child-bearing. LB 23 makes no distinction between a fetus that is viable or nonviable. It does not account for the many things that can go wrong in a pregnancy. It does not account for the complexities and variety of situations to which doctors must respond with their full arsenal of options. There will be situations such as Jane's. It would be a tragedy beyond words if this Legislature, through the threat of criminal prosecution, forced doctors to engage in medical procedures that could so seriously harm a woman like Jane, who is suffering a miscarriage [p. 6420] of a nonviable fetus. We cannot discount the real potentials of this legislation, which could lead to a woman's death, irreparably damage her health, make her sterile, or endanger her ability to carry future pregnancies. I urge you to adopt my amendment.

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[p. 6422] SENATOR LANDIS: Thank you, Mr. Speaker, members of the Legislature. It is an irony because what Senator Schimek is reminding us of is that a woman may well want to preserve her fertility. Her life

may not be at stake, but she may want to [p. 6423] preserve her fertility, and this may be . . . it may bear on that outcome. And it will be interesting to hear why the Right To Life movement would be in opposition to allowing a woman to protect her continued fertility. I will tell you that Kansas did something recently and I think that it's something that we ought to think about. Kansas had a vote in their Senate, recently . . . it was 39 to nothing on this issue, 39 to nothing. It's the only one like it around the country that I know of. And you know what they did? They compromised. Nobody else does. Everybody gets pushed to the wall. Everybody's . . . whoever has got the votes wins the issue. In Kansas, they did their own work, and they said that they would ban all abortions after viability or after the fetus reaches the gestational week of 24 weeks, and that an exception could be made if two doctors, two doctors, determined that an abortion would be necessary to save a woman's life or to prevent the serious risk of substantial and irreversible impairment of a major bodily function. The measure would also outlaw partial-birth abortion unless necessary to save a woman's life. The bill is pending in the House Judiciary Committee. In other words, it is possible to fashion compromise. I doubt if we'll do it here. In fact, the proponents of the bill are prepared to allow a woman's fertility to be placed on the altar of the political agenda and to be forsaken. To take it out of the private domain of her decision-making, along with her doctor, and to make it an object in a greater cultural war between those who want to use the government, to use its power and its ability to coerce to win the choice-life fight that's out there. And one of the casualties of that is a woman's fertility. It must be ironic.

It's an irony I can't appreciate myself, being a man. If I was a woman sitting at home watching the Legislature, listening to David Maurstad and myself trade barbs in exchanges and speeches and to find that the green copy of this bill will basically say, if the choices between the political agenda of the proponents and the fertility of that woman whose watching . . . it's not her decision, it's our decision, and if we have the majority rule . . . it does not have a sufficient ethical gravity. It does not have a sufficient moral imperative to counter the proponents and their desire to pass this bill in its current form. I support the Schimek amendment. And those who watch us on TV, I think, need to see that this is the kind of problem that we get into when these bills are used to pass the morality of, in this [p. 6424] case, probably a majority over the objections of a minority.

SENATOR WILL: One minute.

SENATOR LANDIS: And that they're prepared to sacrifice the fertility of women to create a political victory to pass a law to effectuate this end. There is lots of heartbreak in the decision to have a child or not. And there's heartbreak whether you carry it to term or whether the child has so sufficient of a medical problem that the parent's choose, for the sake of their marriage, the sake of their other children, the sake of the woman's fertility, to abort the fetus. It's just not up to us. We are bad arbiters of that heartbreak. We are poor vessels for this decision. It is too intimate, too personal, too multifaceted to allow itself to be captured in the green copy of a bill and to say, we've got it right, . . .

SENATOR WILL: Time.

SENATOR LANDIS: . . . and we solved the problem of where the human misery is here and we know best. We don't. Fertility is too important to be sacrificed to this political agenda.

SENATOR WILL: Thank you, Senator Landis. Senator Maurstad, on the Schimek amendment.

SENATOR MAURSTAD: Thank you, Mr. President. I oppose . . . I stand to oppose the Schimek amendment. I've passed out to you a blue handout that goes through this particular argument and situation dealing with the health of the mother and the argument of threatening future fertility. It's been mentioned . . . I'll emphasize that I'm not a physician. That's correct. I'm asking that my colleagues look at the information that's been provided by physicians. There's been a lot of misinformation that has been developed as a result of this discussion at the federal level, and also throughout the country. As a result, a physician's group has been formed independent of any other pro-life or pro-choice groups that are trying to provide valid medical information to policy-makers as we continue to look at this circumstance. I draw your attention to it. Nancy Romer, M.D., Clinical Professor, Wright State University. In an article . . . "Medical Nonsense" of August '96. I'll read from it: [p. 6425] "There is simply no data anywhere in the medical literature in regards to the safety of this procedure. There is no peer review or accountability of this procedure. There is no medical evidence that the partial-birth procedure is safer or necessary to provide comprehensive health care to women." It goes on. Another . . . Lewis Moralo; Chairman, Department of Obstetrics and Gynecology, St. Clare's Hospital: "The conversion of a fetus presenting as

a vertex to a breach position, as in the partial-birth abortion, is capable of causing an abruption of the placenta and amniotic fluid embolism. This is a dangerous and life-threatening situation. Surely it would not benefit an already sick mother. Partial-birth abortion is major surgery and is extremely harmful to both mother and child. Never, ever, in our 30 years of practice, have I or my colleagues seen a situation which warrants the implementation of the partial-birth abortion. Personally, I cannot imagine why any practitioner would want to resort to such barbaric techniques when other recognized methods are available." It goes on. Another physician, in testimony before the Legislature, our Legislature's Judiciary Committee, February 12: "I think it's important to realize what this procedure . . . ", Paul Hays, M.D. "I think it's important to realize what this procedure asks of us as doctors to do possibly as many as three very risky procedures. One is the dilation of the cervix itself, manually, before it is time for that to occur on it's own, and that runs a risk for pre-term labor in the future. Also, the instrumentation. Putting sharp instruments into a woman's uterus blindly runs the risk of uterine perforation. And the very procedure of reaching into a woman's uterus, turning the baby from a head-first position to a feet-first position is literally prescribed against . . . literally prescribed against by my college of obstetricians and gynecologists. It's forbidden by the *Williams Obstetrics and Gynecology* textbook as being to [sic] entirely . . . as being entirely too risky for many different medical complications that occur." I could go on. It's on your desk. You can go ahead and look at it at your convenience. The situation is, in fact, the partial-birth

abortion causes, as described here, more problems for a woman's fertility, raises the risk of a problem with women's fertility. So the purpose of this amendment I can't agree with for the very reasons that the physicians that understand . . .

[p. 6426] SENATOR WILL: One minute.

SENATOR MAURSTAD: . . . this subject a lot better than I do [sic] have articulated. So I rise in strong opposition to this amendment. In fact, this procedure is dangerous. I don't think that there's anything that can justify the use of this procedure, and as a result urge my colleagues to vote against the Schimek amendment.

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[p. 6436] CLERK: Mr. President, the . . . next amendment, Mr. President, is by Senator Chambers. Senator, floor amendment 251. (FA251 appears on page 1901 of the Legislative Journal.)

SENATOR CHAMBERS: Thank you. Mr. Clerk, I appreciate that. Members of the Legislature, I'm going to tell you what this amendment does, and for the record, I will read the places where it will occur in the bill. At page 3, lines 14, 18, 24, 26. At page 4, line 3. At page 6, line 10. I would strike [p. 6437] "partial-birth abortion" and insert "intact dilation and extraction". What I think we ought to do is at least use the proper medical terminology. If we were dealing with any other procedure, as I had touched on earlier, we would not, in the statute, put pejorative, imprecise, nonmedical terminology as a substitute for the name of a medical procedure. Let me ask Senator Maurstad a question.

SPEAKER WITHEM PRESIDING

SPEAKER WITHEM: Senator Maurstad, will you respond?

SENATOR MAURSTAD: Yes, sir.

SENATOR CHAMBERS: Senator Maurstad, are you aware that this procedure that we've been discussing is referred to in the medical community as "intact dilation and extraction"?

SENATOR MAURSTAD: Senator, and I . . . I don't want to be evasive . . .

SENATOR CHAMBERS: Let me ask it a different way.

SENATOR MAURSTAD: Yeah.

SENATOR CHAMBERS: Do you think the insertion of this term would change what the bill is designed to do?

SENATOR MAURSTAD: Yes, I do.

SENATOR CHAMBERS: Tell me how you think that would happen.

SENATOR MAURSTAD: Well, first of all, Senator, the terminology that you propose is not in any . . . is not a medically accepted term either. It is used by those that perform abortions, but is not medically recognized itself.

SENATOR CHAMBERS: Let . . .

SENATOR MAURSTAD: I think that "partial-birth abortion", as it . . . as we use it and as it is defined, is clearly understood and can thereby be enforceable.

[p. 6438] SENATOR CHAMBERS: Senator Maurstad, are those who perform abortions, I mean legally now, . . .

SENATOR MAURSTAD: Correct.

SENATOR CHAMBERS: . . . are they physicians?

SENATOR MAURSTAD: Yes, they are.

SENATOR CHAMBERS: Are they members of the medical community?

SENATOR MAURSTAD: Yes, they are.

SENATOR CHAMBERS: If the term "intact dilation and extraction" is used to a group of physicians, even if they're all against performing abortions under all circumstances, would they know what that term means?

SENATOR MAURSTAD: Not necessarily, because it is not defined in any standard medical textbook or database.

SENATOR CHAMBERS: So you think when I use this term, nobody . . . you don't know what I'm talking about either?

SENATOR MAURSTAD: I'm saying that it could be misunderstood as to what it means. Even in the abortion community, D and E and D and X are used interchangeably, and they're not the same, and so . . .

SENATOR CHAMBERS: I'm going to ask you the question again. If a physician were to walk into this room, unaware of our discussion, and I were to ask the physician, what does intact dilation and extraction mean,

you're telling me that that physician wouldn't be able to tell me? The physician, in your view, would say, well, that's a term that has no medical definition and I don't know what you're talking about?

SENATOR MAURSTAD: No. No. There would be physicians that would be able to give their definition for it. But as far as using it as a reference in a court of law, it is important that we use a term that has and is understandable.

[p. 6439] SENATOR CHAMBERS: All right. Then let's use the term you selected. You already on this floor described it as meaning something different from what it says.

SENATOR MAURSTAD: No, sir, I did not.

SENATOR CHAMBERS: Partial . . . yes, you did. You said, when all of the child has emerged except for the head. You said that, and if you forgot it, I'll get the transcript.

SENATOR MAURSTAD: No, I did say that, and I also followed it up by saying that that was an accurate example of the definition provided in the bill.

SENATOR CHAMBERS: But that's not what the definition says, is it?

SENATOR MAURSTAD: It is not the only example.

SENATOR CHAMBERS: No, come on.

SENATOR MAURSTAD: But it is an accurate example.

SENATOR CHAMBERS: Now stop being evasive.

SENATOR MAURSTAD: I'm not.

SENATOR CHAMBERS: Now you are being evasive.

SENATOR MAURSTAD: No. Now, I don't . . .

SENATOR CHAMBERS: Read . . .

SENATOR MAURSTAD: I don't . . .

SENATOR CHAMBERS: Read . . .

SENATOR MAURSTAD: I don't mean to be.

SENATOR CHAMBERS: Read the definition for me.

[p. 6440] SPEAKER WITHEM: Senators, both of you. This discussion back and forth is an appropriate way of debating bills, but it's important that the senator, I think, who has the floor be able to ask the questions and then the individual be given an opportunity to respond. So, continue, Senator Chambers.

SENATOR CHAMBERS: Thank you, Mr. Speaker. Senator Maurstad, to give you an opportunity to continue, read the definition of "partial-birth abortion" for me, if you will?

SENATOR MAURSTAD: "Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery."

SENATOR CHAMBERS: Now, what does "partially" mean?

SENATOR MAURSTAD: Senator, I . . . "partially" means a part of.

SENATOR CHAMBERS: But it doesn't mean as much as what you stated in your earlier description.

SENATOR MAURSTAD: It could mean . . . if I could respond.

SENATOR CHAMBERS: Okay. Go ahead.

SENATOR MAURSTAD: Can I respond?

SENATOR CHAMBERS: Yes. Yes.

SENATOR MAURSTAD: It could mean . . . "partially" would mean everything up to completely.

SENATOR CHAMBERS: It . . . so it could mean one thing and it could mean something else.

SENATOR MAURSTAD: There are many, many definitions of many examples that could fit in to the definition of "partially".

SENATOR CHAMBERS: So there is not one single definition. Is that what you would say?

[p. 6441] SENATOR MAURSTAD: That's correct, but . . .

SENATOR CHAMBERS: Okay.

SENATOR MAURSTAD: . . . "partially" would be the opposite of "completely".

SENATOR CHAMBERS: Okay. And you think that the language that I'm offering would confuse people,

it would lack precision, and there are people who are in the medical profession who would be incapable of saying what this means, even though there is a definition for it in the statute?

SENATOR MAURSTAD: I don't . . .

SENATOR CHAMBERS: If you defined this term . . . let me ask you this: Do you think the definition that you have placed in this bill, pursuant to the language given to us by National Right To Life, if you used the term that I'm suggesting and attached the definition that is in the bill, are you telling me that that definition does not define the term that I'm talking about? Is that what you're telling me?

SENATOR MAURSTAD: Yes, that's what I'm telling you, and if . . . I'll give a slight explanation on it, if you . . . I don't know how much time you have left.

SENATOR CHAMBERS: Then let me ask you this: What . . . based on your understanding, what does the term that I'm talking about mean to those who understand it? What does it mean?

SPEAKER WITHEM: Senator Maurstad, can you respond to that?

SENATOR MAURSTAD: Yes, sir, Mr. Speaker. Intact . . . I don't have your amendment right in front of me, I want to be . . .

SENATOR CHAMBERS: "Intact dilation and extraction". The term.

SENATOR MAURSTAD: My definition or my explanation of what "intact dilation and extraction"

would mean the procedure. Mr. Speaker, I going to have to . . . I don't know how much time he has left, but to give him . . .

[p. 6442] SENATOR CHAMBERS: Take it.

SENATOR MAURSTAD: Senator, to give you an explanation I'm going to have to go through the information that I've provided and it is on the record in General File as to what "partial-birth abortion" is and what could be another term of it could be "intact dilation and extraction". It is the partial removal of a child, and at that point in time, when we're talking about an abortion, it would be the killing of that child and then the extraction of it. The further delivery.

SENATOR CHAMBERS: So you know what the term means?

SENATOR MAURSTAD: As you know what the term "partial-birth abortion" means, Senator.

SENATOR CHAMBERS: Well, actually, I thought I did until I heard you tell me there are these different meanings of it. So what's in the bill is what we can't agree on, and you're not even precise on it because, Senator Maurstad, it's an imprecise term. The fault is not in you. You discussed the term the way anybody would have to discuss it. It is not a precise term, or do you think that it is?

SPEAKER WITHEM: Senator Maurstad.

SENATOR MAURSTAD: "Partial-birth abortion" to me is a precise term that is plain and easily

understood by those that would need to comply with the statute, and that's what's important.

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CLERK OF THE LEGISLATURE
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May 14, 1997

LB 23, 660A

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[p. 6751] CLERK: LB 23, Madam President, has been discussed on Select File. Enrollment and Review amendments have been adopted. Senator Brown had an amendment that was adopted. When the Legislature left the bill, yesterday, Senator Chambers had offered FA251. Senator, that amendment is on page 1901 of the Journal.

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[p. 6754] SENATOR CHAMBERS: So, I am saying, in my amendment, that you ought to at least call this procedure by a name which is more appropriate than . . .

SENATOR CROSBY: Time.

SENATOR CHAMBERS: . . . partial-birth abortion.

SENATOR CROSBY: Thank you, Senator Chambers. We do have a Doctor of the Day today. Dr. Reynen from the 25th District, Senator Warner's district, but I don't see him at the moment. But he is here. Also, Senator

Janssen has 44 fifth graders as his guests today from Lincoln Elementary in Fremont, Nebraska. (Introduced teachers.) They're in the north balcony. Would all of you please stand and be welcomed by your Legislature. Thank you for being here. Discussion on the Chambers amendment. Senator Maurstad.

SENATOR MAURSTAD: Thank you, Madam President. I rise in [p. 6755] opposition to the Chambers amendment. Excuse me. On General File, we went through the process of providing, for the record, what the definition of a partial-birth abortion would be . . . as in LB 23. So I'm not going to go through that whole definition again because that's already been provided. The bill adequately defines partial-birth abortion. The terminology needs to be clearly and precisely descriptive of the action that is to be forbidden. Partial-birth abortion does that. There is not consensus among abortion practitioners, what to call this procedure . . . it's been called "dilation and extraction", it's been called "intact dilation and evacuation", the Chambers amendment would call it "intact dilation and extraction". In the media and the press through this whole discussion, those terms have been used interchangeably. As a result, it would not- . . . the description that is being used and proposed by Senator Chambers would not satisfy the requirement necessary in criminal law to be precisely descriptive. It is, in fact, a pseudomedical jargon. There's no terminology in any textbooks, medical textbooks that refer to this language. And so for those reasons, in addition to that it is plainly described in the bill itself, I oppose the Chambers amendment, would ask my colleagues to vote against the Chambers amendment. Thank you.

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[p. 6760] SENATOR ABBOUD: Thank you, Madam President. Would Senator Maurstad yield to a question?

SENATOR MAURSTAD: Yes, Madam President.

SENATOR CROSBY: Senator Maurstad, will you respond?

SENATOR MAURSTAD: Yes, ma'am.

SENATOR ABBOUD: Senator Maurstad, I had . . . this is more of a definitional question. I have one particular question. In the language on the committee amendment which we're on right now on page 3, lines 14 through 17 where it describes the partial-birth abortion, defines it . . . it means: "An abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child [p. 6761] and completing the delivery." I've . . . I think like most of us here, we've heard a lot about these partial-birth abortions and what exactly . . . what are exactly . . . I'm trying to figure but what exactly they are in that this definition appears to be a situation that would apply under current law. If a child is born, a child's alive, and then the child is killed, that appears to me to be murder or manslaughter or . . . you know, it'd be one of those definitions in which a person takes another person's life. And how would . . . how is this different than what the current law is with this type of a procedure?

SENATOR MAURSTAD: Senator, I believe what is at issue is whether or not . . . when that child is fully delivered or not, or at what point in time the child

receives the status that you refer to where infanticide or murder, as you referred to it, would be the . . . would be the issue. So what the point of all of this is that you have a circumstance where it's unknown what in . . . by current law, what the legal rights of that partially-born child would be, and that's one of the purposes for this legislation, I believe, is to make sure that this particular procedure doesn't occur.

SENATOR ABBOUD: Let me ask, maybe, a more specific question. In trying to define this, I understand that this is kind of the crux of the bill here. Where I think a couple of the key terms are the "partially delivers vaginally". What does that mean? Or what's your- . . . what's your feeling . . .

SENATOR MAURSTAD: That means that the . . .

SENATOR ABBOUD: . . . as far as the definition of that?

SENATOR MAURSTAD: . . . living unborn child is not completely delivered from the vagina.

SENATOR ABBOUD: Um-hum. Well, what does that mean. I don't understand. Does that mean that the child is outside the body of the mother or does that mean that the child is still inside?

SENATOR MAURSTAD: Part of the child is outside of the mother and part of the child is not.

[p. 6762] SENATOR ABBOUD: Okay. And when we say "a living unborn child", how do you define that?

SENATOR MAURSTAD: A living unborn child?

SENATOR ABBOUD: Um-hum.

SENATOR MAURSTAD: "Unborn" would be . . . would mean that the child is not completely delivered or outside of the mother. "Living" is living. It's the opposite of death.

SENATOR ABBOUD: I think . . .

SENATOR MAURSTAD: I'm trying to be as clear as I can.

SENATOR ABBOUD: I understand that.

SENATOR CROSBY: One minute.

SENATOR ABBOUD: I just . . . I think you ought to realize here that we're talking about prosecuting these people under a Class III felony and when they're looking . . . when we're looking to prosecute these people . . . I think this bill is going to pass like Senator Chambers has stated earlier, and I do support this bill and I plan on supporting it. But when this . . . when the law hits the reality of the prosecutors around the county . . . around the state, start prosecuting individuals who perform these types of operations, I think we need to provide additional guidance as to these definitions to properly prosecute and convict these individuals, or else I think you have some problems with the bill. And I'll discuss this with you off the floor, but I think, probably, in the legislative history there should be some further definitions on this, and maybe there is nothing more that

you can provide from what you've described to me, but I did . . .

SENATOR CROSBY: Time.

SENATOR ABBOUD: Thank you.

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[p. 6763] SENATOR SCHIMEK: Senator Maurstad, I'm not very . . . I'm really not very certain of some of these medical terms that I've been reading about and I'd like to clarify a little bit more, if we could, the . . . your understanding of what a partial-birth abortion means. And as I understand it, there are two different kinds of procedures and one is called the "intact D&E" or the "D&X" as it's referred to in some literature, and then there is the "D&E". And I am wondering if partial-birth abortion refers to both of those procedures. Now I heard you say, earlier, when Senator Chambers was asking questions, that this referred to an intact D&E. Is that correct? Is that your understanding.

SENATOR MAURSTAD: No, I don't believe I did say that. I think that what I indicated was in the press that it has been referred and described in a number of different ways. If I could . . .

SENATOR SCHIMEK: That's the problem, Senator Maurstad. I don't think there's a clear understanding of what this terminology means and I agree with Senator Abboud that there might have to be, at least, some discussion for the record of what we're really talking about here. So could you elaborate a little bit?

SENATOR MAURSTAD: Yes, Senator Schimek, Madam President. I can go through what my opening of

General File again where I described, for the record, what I meant by a partial-birth abortion if you would like me to do that. I can secure . . .

SENATOR SCHIMEK: Could you . . .

SENATOR MAURSTAD: I can secure that . . .

SENATOR SCHIMEK: Could you give me a one sentence . . .

SENATOR MAURSTAD: The . . .

[p. 6764] SENATOR SCHIMEK: . . . or two sentence definition, Senator?

SENATOR MAURSTAD: No, probably not. That's the whole issue. The terms that have been used, "intact dilation and evacuation", "extraction" . . . you know, they may have a broader or more restrictive definition than what is in the law itself, and that's why I provided on General File, and I can go through the description again of what I believe a partial-birth abortion is.

SENATOR SCHIMEK: Well, Senator Maurstad, if you can't give it to me very . . . in a very compact style, I'll get the transcript from the testimony that you gave on General File and I'll look that over and see if it's any clearer to me. But I'm not sure that that's going to . . . I mean, it seems to me for the average OB/GYN out there, they might need some clarity in the statute.

SENATOR MAURSTAD: Well, if you want me to take your time, I will go through what it is again.

SENATOR SCHIMEK: No, no, no. I mean in the statute itself.

SENATOR MAURSTAD: Okay.

SENATOR SCHIMEK: They're not all going to have the time to read the record of . . . or the transcript of what we say here. I'm just thinking in practical and legal terms here. The other thing is . . . I'm wondering . . . I have become aware, since we were on the last bit of debate that we did on this, that there was a case in Ohio that provided some injunctive relief and prevented Ohio's bill from being enacted . . . or implemented, I should say. It was enacted, but it was implemented, and that case has been appealed to the Sixth Circuit, I believe, and that was heard this month, if I'm correct in my information.

SENATOR CROSBY: One minute.

SENATOR SCHIMEK: And that decision hasn't been handed down yet. But the implications were that this procedure which we call "intact D&E", or whatever we call it, could not constitutionally be prohibited. And . . . you don't have time to answer that now, but maybe you'd like to do that on your own time, or, my time [p. 6765] later on. Thank you.

SENATOR CROSBY: Thank you, Senator Schimek. Senator Witek, on the Chambers amendment. Senator Witek. I don't see Senator Witek. Senator Maurstad, your light is next. Senator Maurstad.

SENATOR MAURSTAD: Thank you, Madam. President. I think some of what I was going to say when I turned my light on I've already said relative to the aspect of the meaning. I think the meaning is very clear. I think anyone that wants to sit down and objectively look at

what Section 9 . . . subsection (9) of Section 2 means, understands that we're talking about a procedure where "a person performing the abortion partially delivers . . . ", I think people know what"partially" means and what "delivers" means, " . . . vaginally a living unborn child." I believe that people understand and know what that is. I believe that the language is very clear. I will provide for Senator Schimek my comments on General File while I provided what I felt was the definition for guidance for those that would look into the record for that . . . for that direction and guidance, which I think is important. But even so, I think that the way that the language is in the bill is clear and it [sic] understandable and once again would reiterate . . . ask my colleagues to vote against the Chambers amendment.

* * *

[p. 6767] SENATOR CHAMBERS: Thank you, Senator Kiel. Madam President, members of the Legislature, for something which is so clear, Senator Maurstad and Senator Witek are finding it to be an impossible task to explain what it is that is so clear. He keeps saying people know and understand what this language means, but he doesn't know and understand what it means. He keeps saying the language is very clear, and I noted this as he said it. But he keeps wanting to refer you to the record and what was said on General File, which I will conclude, since I was not here to listen, that he must have read something that somebody else stated, so he doesn't know. But one thing I want to make everybody understand, and I'm glad Senator Abboud brought it up, when you look at the criminal law you cannot go outside of

what is written in that law for the purposes of prosecution. And the criminal law is always strictly or narrowly construed. The court cannot infer anything, it cannot extend the actual words to encompass something that is not clearly encompassed by those words. If there is any ambiguity in a criminal statute, it's struck down as unconstitutional. And the courts have ruled so many times in this area that I'm surprised that the legal staffs of some of these people haven't told them that. A person must be clearly apprised of what conduct is allowable and that which is prohibited. And if there is any ambiguity in the statute, the statute is struck down. If there is ambiguity in the document used to charge a person, whether it's in information and indictment, a complaint, that complaint is dismissed. Ambiguity always is resolved in favor of the accused. So if you're going to look at the record at all, you will see that those who are bringing this bill don't understand it. They remind me of a song that Harry Belafonte sang. It went something . . . and I'm not going to sing it, when I was a lad, just three foot three, certain questions occurred to me. So I asked my father, quite seriously, to tell me the story about the bird and the bee. He stammered and he stuttered pathetically, and this is what he said to me. He said, the woman Piaba, the man Piaba, the cane stand tall like the lemon grass. The lily root, gully root, belly root, ummm, And the [p. 6768] famous gunny scratch, scratch. And the little boy says, and this is what I say about their definition, it was clear as mud, but it covered the ground, and the confusion made me brain go round. So I grabbed the boat and I went abroad, and in Baden, Germany met Sigmund Freud. He said, son, from your sad face remove

the grouch, put the body upon the couch. I can see-from your frustration a neurotic sublimation. Love and hate is psychosomatic, your Rorschach shows your [sic] a parapatetic. It all started with a broken sibling in the words of the famous Rudyard Kipling. So then the little boy says again that it was clear as mud, but it covered the ground, and so forth. So then he says . . . well, I probably don't have enough time to give you the next stanzas. I will do that if I get a chance. But the point I'm trying to make is this, people, rather than being able to convey to us the meaning of these terms, will do a lot of talking and say a lot of words which only obscure, and they want it to seem as though they have said something meaningful, when they haven't. If Senator Maurstad does not know what he said and cannot repeat it for the record now but must say, go back to what I said on General File, it means that he doesn't even know . . .

SENATOR CROSBY: One minute.

SENATOR CHAMBERS: . . . what he said. He does not know what these terms mean, and he understands that they're imprecise. Mine, my amendment would lend a measure of precision that his lacks. So, as I stated, they cannot accept my amendment, and I know it. But by virtue of the fact that they deliberately want to retain an obviously ambiguous term, the meaning of which they don't know, over a term that brings more certitude in the case that they want to inject into the statute "unclearness" as a trap for the unwary.

SENATOR CROSBY: Thank you, Senator Chambers. Senator Schimek.

SENATOR SCHIMEK: Thank you, Madam President, members of the body.

SENATOR CROSBY: Senator . . .

SENATOR SCHIMEK: This, frankly, is a very difficult issue and a [p. 6769] very upsetting issue. And I am sorry to prolong the discussion. But, Senator Maurstad, I'm still not clear on your definition. In your opening statement it indicates that this procedure involved the suctioning of the baby's brain. And according to what I have read, in the *Voinovich* case, that refers only to the intact D&E procedure. It does not . . . it does not refer to the . . . the D&E procedure that does not leave the baby intact. And I want to know if your definition . . . what your definition includes for sure. Senator Maurstad, would you be willing to answer the question?

SENATOR CROSBY: Senator Maurstad, Senator Maurstad.

SENATOR MAURSTAD: I apologize, Senator Schimek, I didn't realize you were going to ask me a question. I thought you were making a statement, so I was on the phone. If you could re . . .

SENATOR SCHIMEK: That's all right. Let me ask it very simply. Your statement talks about the suctioning of the babies brain. If the procedure does not involve that, is that referenced then under this statute? And I apologize for bringing the graphics into this, but all I'm trying to illustrate is I don't think this is a definition that will legally stand the test.

SENATOR CROSBY: Senator Maurstad.

SENATOR MAURSTAD: Senator, I'm trying to cooperate. But I need to understand what your question is. You answered . . . I mean you end up making a statement. I don't know if you want me to respond to your statements or . . . I mean . . .

SENATOR SCHIMEK: Which ever you prefer, Senator Maurstad.

SENATOR MAURSTAD: Okay. Well, I would indicate that the definition that is in the law that would provide the guidance is easily understood, that the terminology is clear.

SENATOR SCHIMEK: Well, then I . . .

SENATOR MAURSTAD: I know what this means. I think you know what this means when we talk about partially delivers vaginally a living, unborn child before killing the unborn child and [p. 6770] completing the delivery. I think you know what that means.

SENATOR SCHIMEK: All right. Then let me approach this another way, Senator Maurstad. Does it refer to a nonviable fetus?

SENATOR MAURSTAD: There is no reference in the definition to viable or nonviable.

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[p. 6771] SENATOR WITEK: Thank you, Madam Chairman, members of the Legislature. I'm just going to read a little bit from the Congressional to try to clarify, because it's very clear to me, but I want to make sure that no one is being confused by this discussion. We're talking about a new category, we're talking about

children who are partially born. Prior to this discussion and the abortion decisions, they talked about unborn children, that's in all the statutes, unborn children, all the case law, everything that they've talked about. We also talk about children who are born. We have statutes that cover these children who are born. What we do not have is children who have been partially born, and that's why we came in with LB 23 this year, Senator Maurstad, because we have to go into this area of the partially born child and discuss how we want to handle this specific procedure where a child is delivered partially, the head or whatever portion is still within the mother, and they puncture the base of the skull and suction out the brain of the child, it is that procedure. The reason it doesn't have a specific medical procedure, Senator Maurstad has handed that long ago onto our desks. And I hope those people who are confused have looked this over. It talks about the . . . there is no consensus, even among the abortion practitioners about what they call this procedure. One doctor calls it a D&X, another calls it a D&E. When the partial birth abortion ban was enacted, or was written in 1995, neither the D&X, nor the intact D&E appeared in any medical dictionary or in any medical data base, nor did either term appear in the textbooks on abortion methods, abortion practices by late -term abortionist, specialist, Dr. Warren Hern. What we're talking about is a legal term, that's why we use partial-birth abortion, because we have to go into the area of the legal term. These terms, D&X or intact D&E, originated as a kind of pseudo-medical jargon, which should not be employed in criminal law because of the risk that courts will declare that the law to be void on vagueness. Partial-

birth abortion was chosen to satisfy the requirement that criminal laws must be precisely descriptive of what is forbidden in order to pass constitutional muster. And that's the discussion that Senator Chambers is trying to raise, wrongly I say, because this is very graphically described a number of times in debates, both on the floor of Congress and here and in testimony in front of the Judiciary Committee. I think it is [p. 6772] very clear the procedure that we are trying to discuss and to ban in the state of Nebraska. It's been thoroughly discussed. And I think if . . . maybe it's just that people need to look again at the information that Senator Maurstad has provided to us on the floor and read that over again and see that this is written very well and precisely so. It will be able to encompass any of the medical jargon that may be out there. And that's why Senator Maurstad has chosen the specific term of partial-birth abortion. So it is a new category, not unborn, not born; but a partial-birth. And that's why we need to do this in the first place. Thank you.

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SENATOR CHAMBERS: Thank you, Senator Schimek. Madam President, members of the Legislature, every time Senator Witek or Senator Maurstad tries to tell us how clear this is, they have to read something which they don't even understand. She doesn't even understand what she was reading. And then she said, I want to read this so that it's clear to everybody and nobody on the floor is confused, or something to that effect. She's confused. She cannot even paraphrase what she read. She trots in and out as they give her stuff to read, and they probably say, now preface this with this is so clear that a

fool cannot err. Then she has to read it and doesn't know what it meant.

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[p. 6773] Senator Witek, in which dictionary will I find a definition of partial-birth abortion?

SENATOR COORDSEN PRESIDING

SENATOR COORDSEN: Senator Witek, would you respond to a question, please.

SENATOR WITEK: I would say at some point in time, after we [p. 6774] determine this bill, it will be in the dictionary, probably in every dictionary.

SENATOR CHAMBERS: No, I'm asking, where is it now?

SENATOR WITEK: The whole reason for having this discussion, Senator Chambers, is because at this point in time we have . . . we have law on an unborn child and a born child, but we don't have the partial-birth discussed.

SENATOR CHAMBERS: I know it's hard for you to understand English, but I'm going to try again. Is there a definition . . .

SENATOR COORDSEN: One minute.

SENATOR CHAMBERS: . . . of partial-birth abortion in a dictionary that you know of?

SENATOR WITEK: There is a definition for partial, there is a definition for born, and there is a definition for abortion.

SENATOR CHAMBERS: Well, born is not even a part of what we're talking about. I'm talking about birth. You . . .

SENATOR WITEK: There is a definition for all three of those words in the dictionary, Senator.

SENATOR CHAMBERS: Is there a definition of the term partial-birth abortion?

SENATOR WITEK: Senator, why would there be a definition in the . . .

SENATOR CHAMBERS: Thank you, Senator Witek. Do you see why it is so difficult here? She doesn't even understand the term that I'm asking her about. She doesn't understand what I mean when I ask her, is there a definition. lend [sic] she just got through yammering from something she read, and I told you she didn't understand it. They say, well there is no definition of ID&E anywhere, so I asked her, is there a definition of the term you're talking about? And she doesn't then know what the term, is there a definition, refers to. And she and Senator Maurstad [p. 6775] are the experts in the law who are going to tell us what these words mean, when they don't even know what it is they're talking about. It's preposterous.

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[p. 6784] SPEAKER WITHEM: Mr. Clerk, would you please call the roll on the adoption of the Chambers' amendment.

CLERK: (Roll call vote taken. See page 1979 of the Legislative Journal.) 11 ayes, 27 nays on the amendment.

SPEAKER WITHEM: The amendment is not agreed to.

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SENATOR KIEL: Broke. Thank you, Mr. Speaker and members of the Legislature. I am offering amendment today which would provide an exception to the prohibition of intact D&E, if a woman is at serious risk of substantial impairment of a major bodily function. This is language that is currently in state statute, you will find it in 28-326, under the definition of "emergency situation", which was adopted in 1993. And since most of you will probably not have it in front of you, I'll read the language in the statute. Emergency situation shall mean that condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death, or for which a delay will create serious risk of substantial impairment of a major bodily function. That's the language that's in the statute now, and that is why I'm now offering it as an amendment to this proposed bill. The reason I'm offering it as an amendment to this bill is based upon constitutional issues, that is a woman's health must be a consideration in the performance of an abortion. We, as a state, have included this exception partly, I hope, because we hold that a woman's health is vitally important. But I want to take this opportunity very briefly to address some claims and issues surrounding a health exception required under constitutional law. I will tell you that I find offensive claims that this exception includes, among other things, a woman hates being fat, a woman hates

giving birth, a woman just, hates [p. 6785] being pregnant, a woman considers that a pregnancy is interfering with her career goals, a woman hates being pregnant because she can't afford a baby and a new car, and that a woman has changed her mind, wanted one yesterday and doesn't want one today. These are outrageous claims, but they also confuse the matter when, in a pregnancy, the health exception becomes a factor under constitutional law, and under current Nebraska law. Prior to viability of the fetus, the state cannot ban abortion. After viability, which is roughly the third trimester, the state can and does ban abortion, except when necessary to preserve the life or health of a woman. To claim that a woman would seek an abortion in the third trimester of pregnancy for one of the reasons I just stated is a grievous insult to all women. Does anyone truly believe that in the seventh, eighth, or ninth month of pregnancy a woman would decide she wants an abortion because she hates being fat, or wants to buy a car? Can you imagine a physician who would jeopardize his or her career and livelihood by performing a third trimester abortion for these reasons? I can't imagine that. But, getting back to the health exception, a federal court ruled on the health exception in United States v. Voinovich, this was in 1971, two years prior to the U.S. Supreme Court Roe v. Wade decision, which made it very clear that a health exception was a constitutional must. In its 1973, *Doe v. Bolton* decision, the Supreme Court again protected the health exception, stating, the attending physician's best clinical judgment that an abortion is necessary should be sufficient. It went on with words I'm going to emphasize, "If a physician is licensed by the state, he is recognized by the state as

capable of exercising acceptable clinical judgment." Thirteen years later, in 1986, *Thornburg v. American College of Obstetricians and Gynecologists*, the high court ruled the law unconstitutional because it required "a trade-off between the woman's health and fetal survival and failed to require that maternal health be the physicians paramount consideration." The court not only ruled on the health exception in *Thornburg*, it addressed the primary question before us today, that question is, who will make the decisions about medical care, doctors or legislators? In *Thornburg*, the court ruled that when performing a post-viability abortion a physician must have the authority to choose the method most likely to preserve his patient's health, even if it might jeopardize fetal survival. More recently, in 1992, the court upheld the central ruling of Roe and Planned [p. 6786] Parenthood of Southeastern Pennsylvania v. Casey. And we cannot ignore, I think as Senator Schimek has mentioned before, an ongoing case, which is the *Women's Medical Professional Corporation v. Voinovich*. In 1996, the district court permanently enjoined an Ohio law, similar to this proposal. The matter is currently before the Sixth Circuit Court of Appeals. This should give us, I would think, pause for thought. There are some other cases on point that I will probably speak to later on in this debate. But one of the things I want to make clear is that the Supreme Court has been consistent and explicit on a health exception and has made it clear that doctors are vested with the responsibility to make medical determinations about a patient's care. I hope and trust that the Legislature will adopt language that's already in statute that will provide some protection or [sic] a woman's health. Thank you.

SPEAKER WITHEM: Senator Wesely, to debate the Kiel amendment.

SENATOR WESELY: Thank you, Mr. Speaker, members, I rise in support of the Kiel amendment. And I appreciate that she's willing to raise the issues that she is. I want to follow up on the previous discussion I started, dealing with the medical aspects of this issue. I continue to be concerned about the fact that we are dictating in here a medical procedure, again, recognizing that as it's been described, as most of us in the public see it, as an abortion procedure, as gruesome and objectionable, but there are other situations that apply that I want to follow up on, and again indicate that we're not dealing with just the aspect of abortion, but there are other situations where this legislation will apply. And how it will impact physicians in carrying out their medical duties has me concerned. Let me continue and follow up to another letter from a physician, again dealing with this issue. My concern with nonmedical personnel trying to dictate medical procedures includes telling a physician which procedure to use and how to do something. If there are three procedures, A, B, and C, and the decision is to do either A, B, or C, has to be made by a medically trained individual using the patients' age, health risk for infection and for hemorrhage. If you decide that C is not acceptable and make it illegal, you have limited physicians' choice and put a patient's health at risk. I do not try to make light of anyone's special training. I know my limitations, try [p. 6787] to depend on people that have the facts to educate me or do things for me that I'm incapable of doing. A person who decides to spend 12 years of post graduate training working 100 to 120 hours

a week to become a doctor requires hundreds and thousands of facts and hours of experience with which to make medical judgments. A spontaneous AB does not always involve a dead fetus. I would say before 12 weeks, 99 percent are dead. After 12 weeks the error becomes much greater, and this is my concern. The way the bill reads, if a woman would come in between 14 and 24 weeks with a premature labor and the cervix dilated, or an incomplete cervix with the cervix dilated, or with premature ruptured membrane, or a chorioamaniontis, we are faced with a pregnancy that we aren't able to save. In those cases it is best to go ahead and proceed with completion of what nature has begun. But by the definition of partial-birth abortion in your bill, if we have a heart rate and proceed, then we have to be . . . then we would be at risk for loss of our license, censorship, criminal charges, et cetera. The reason a physician would go ahead at this point instead of waiting for the baby to die is to decrease the risk of infection, therefore decreasing the risk of scaring of the uterus and tubes and causing sterility. To wait for the placenta to separate or partially separate so that the fetus bleeds to death and the mother, losing a lot of blood, possibly causing death or the need for transfusions, or the risks for hepatitis and AIDs is very distressing. Are we arguing over words that need to be changed, such as spontaneous, elective, incomplete, or induced? If an AB is started on its own, can the physician finish it to help prevent these medical complications for their patient as I've described? These incidents happen much more often than we would hope they would, and this is just not a patient or client to me, this is a person. It

is someone I am caring for. If it is your wife, your daughter, or your granddaughter, I am certain that you wouldn't want me to have my hands tied, not to be able to do the correct medical treatment. As I said before, law and writing bills is not my forte, but the way I read this bill as written it would prohibit us from taking care of patients in these tragic situations. Again, the concern is what are the implications beyond the particular situation that we've heard described previously about a live fetus being drawn forward and . . .

[p. 6788] SPEAKER WITHEM: One minute, Senator.

SENATOR WESELY: . . . this partial-birth, or the other terminology Senator Chambers had us look at, this procedure going forward. Personally, I plan on supporting LB 23 and the thrust of what they're trying to do. But I also think that being careful about the language, and I think Senator Kiel is trying to make this point, let's be careful about the language in the bill, has implications beyond the obvious, beyond the simple case that's being made. And we need to understand those implications. And I do hope that we will consider carefully what we're doing here, it has an impact beyond what I think we've discussed so far. Thank you, Mr. Speaker.

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[p. 6790] SENATOR LANDIS: Mr. Speaker, members of the Legislature, I support the Kiel amendment. And, by the way, with it I think I would vote for LB 23. The issue should be when this, if this is going to be outlawed, and it's obviously going to be outlawed in this

state, if this is going to be outlawed, what are the exceptions. Unfortunately we have limited the life exception in a way that we've never limited the life exception before. There is also a standard practice in our statutes to recognize a set of concerns greater or more than simply the life of the mother, and those are included for health. Opponents of or supporters of this bill, rather, have always been concerned about the use of the word "health" because it implied mental and emotional stress and could be used in a wide variety of circumstances. Senator Kiel is asking not about that, what she's saying is losing an important bodily function, who among us claims the wisdom of a Solomon that can say a woman, by law, is to be denied a procedure that could maintain an important bodily function, and that, if we pass this law and we're going to outlaw the procedure, that we dictate, as a matter of law, that she lose an important bodily function? It is of concern to me that we take too much towards the end of our legal ability the moral authority to deny a woman here continuing fertility by law, the use of an arm, the use of a kidney, the use of a full lung capacity, whatever it might be, this loss of physical well-being. I know that we're trying to stop and the supporters want to stop a practice that they find brutal and horrific. But understand the cost at which you are doing that. And that's to say by law a woman has to give up her . . . an important medical and physical well-being simply because it doesn't rise to the level of life-threatening. It's okay if she loses a kidney, it's okay if she loses her fertility. This is beyond our ability to rule and judge and evaluate when we place into the scale of our own sense of justice the moral implications of the fetus and the moral

implications of the mother and her continuing fertility. This is not a place for us to act. This is a place for a woman, her doctor, her source of moral advice and counsel, the well-being of the family, this is not for 25 legislators to rule which parts of a woman's physical well-being must she surrender on the altar of politics and the cultural war agenda of the extreme right. This is not a place for us to act. I support the Kiel amendment. I know it will fail. Senator Chambers is [p. 6791] right. I see a letter here on the desk that says . . .

SPEAKER WITHEM: One minute.

SENATOR LANDIS: . . . . the Christian Coalition says no amendments. Those of you who get this letter, get your marching orders from the Christian Coalition, 23 with no amendments. We can't consider the notion of a woman's physical well-being, not emotional or even mental, but her physical well-being, and this body's prepared to sacrifice her fertility, the well-being of internal organs, her mental capacity, it could be memory loss, it could be reasoning loss, and we're prepared to do that in this body because LB 23 is to pass without amendment. That is itself horrific as well. Yes, what 23 talks about and tries to outlaw is a horrific phenomenon, but this is horrific as well. And we should not place ourselves . . .

SPEAKER WITHEM: Time, Senator.

SENATOR LANDIS: . . . into picking between these two choices.

SPEAKER WITHEM: Senator Maurstad.

SENATOR MAURSTAD: Thank you, Mr. President. I rise in opposition to the Kiel amendment, and I do that because, as we discussed earlier, there's overwhelming medical testimony insisting that partial-birth abortion is never medically indicated and can itself pose serious risks to the health and future fertility of the mother. I think that as I read and learn more about this I think you can say and I will say that this procedure should not be used for the very reasons that this amendment is being brought, that this procedure is in fact dangerous. And there are other more . . . less risky procedures that can provide an option to the mother. Now I . . . it's been indicated earlier there aren't any physicians in the body, I'm not a physician, but I believe it's important to go to individuals that have given testimony and see what they have to say about this particular procedure and whether it is medically necessary. The Surgeon General, former Surgeon General, Koop, publicly verified that there are no medical conditions, either maternal or fetal that require using partial-birth abortion to preserve the mothers' health or future fertility. There are [p. 6792] others that have provided testimony. And Dr. Harland Giles (phonetic), who performs second trimester abortions up to the point of viability, testified, I do not think there are any maternal conditions that I am aware of that mandate ending the pregnancy that also require the fetus be dead or the fetal life be terminated. There are those that were concerned about the fertility issue, that I think is in essence the heart of this particular amendment. Dr. Donna Harrison (phonetic), this is medical nonsense, there is nothing gentle about grasping the opening of the

womb and thrusting scissors inside to perforate a wiggling head. Indeed, any surgeon can tell you that when you put a sharp instrument, like scissors into a body cavity there is always risk of perforating that organ. As an obstetrician I can testify that this procedure has no medical indication over standard, recognized and tested procedures for terminating a pregnancy. Banning this procedure will in no way compromise the legitimate practice of obstetrics and gynecology. And there is other testimony that I have passed out, on the handouts to everyone, that continue this same overwhelming set of data and information by experts in this field that have indicated that there are other procedures that can be chosen, that this isn't needed, this isn't necessary, this is more risky, and as a result, I think, provides further evidence of the reason why we can in fact indicate that this procedure, as indicated under the *Casey* case, can be looked at and regulated by the state. I'm not an attorney. I'm not going to get into a constitutional discussion, I'll leave that for attorneys that can tread into that water more successfully than I can. But we've somewhat gone through this issue . . .

SPEAKER WITHEM: One minute.

SENATOR MAURSTAD: . . . thank you, Mr. Speaker. We've somewhat gone through this issue so, as I indicated before, in the spirit of not dragging this procedure on by being redundant, I would just say that again I'm opposed to the Kiel amendment. The overwhelming information and testimony that has been provided throughout the country indicates that partial-birth abortion is not needed, not medically necessary to preserve

the life or health of the mother, and as such should not be sanctioned in our state. Thank you.

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TRANSCRIPT PREPARED BY THE CLERK
OF THE LEGISLATURE
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May 20, 1997 LB 23, 271, 658, 752
LR 172-176

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CLERK: When the Legislature left the bill on May 14, Senator Kiel had an amendment pending. I have a note, Madam President, that Senators Brown and Maurstad have had a conversation with Senator Kiel and she wishes to withdraw and allow substitution, by Senator Maurstad, of AM2325.

[p. 7759] SENATOR CROSBY: No objections to the substitution? So ordered.

CLERK: AM2325, Senator Maurstad. (See pages 2157-60 of the Legislative Journal.)

SENATOR CROSBY: Senator Maurstad, to open on your amendment.

SENATOR MAURSTAD: Thank you, Madam President. Members, as sure everyone's aware, this is an issue that has been discussed throughout a number of legislatures across the state (sic) and . . . or across the country, in addition to it continuing to be pursued in

Congress. In fact, today there was a vote on this particular issue that received 64 votes, passing the amendment, bipartisan support, and including that of minority leader Senator Daschle. And what this amendment does is very similar to what occurred there in that it incorporates three items that the American Medical Association felt important that were and have been agreed upon that, in essence, allowed them and their legislative body to be supportive of HR 1122 in Congress. Now people will recall that the bill that I introduced was modeled after the legislation that is in Congress. The first question that might come up is, well, if it's passed the House and it passed the Senate, why do we need to proceed in Nebraska? And, quite frankly, that's because there is still an opportunity for that not to become federal law. With 64 votes, it is 3 short of an override if necessary, assume the bill is moving to the President and he has vetoed similar legislation in the past. So it's important we continue to move on. As I've indicated on General File in my opening and through the discussion, it's been my intent to focus on prohibiting a particular abortion procedure in the state of Nebraska, and I wanted that to be done as clearly as possible. I have agreed to go ahead and incorporate the changes that occurred at the federal level because I think they make the bill clearer, they make the definition clearer, and that has been a concern of the opponents of the legislation and I believe that it does that. I would first, I've handed out a number of different handouts . . . I would first indicate, draw people's attention to the letter from the AMA to Senator Santorum where, in the first paragraph, it indicates, although our

general policy is to oppose legislation criminalizing medical practice or procedure, the AMA has supported such legislation where the procedure was narrowly [p. 7760] defined and not medically indicated. HR 1122 now meets both those tests, and I think that that's important 'cause we've had that discussion before and we've talked about that this is not a medically indicated procedural need. There are . . . I've also handed out a section-by-section description. The first section clarifies the language with respect to the license suspension and revocation, and ensures that the Health and Human Services Director of Regulation and Licensure shall make findings with regard to whether the licensee's conduct was necessary to save the life of the mother if a petition to suspend and revoke the attending physician's license to practice medicine is filed by an Attorney General. The second section clarifies the definition of the procedure. It further defines the term "partially delivers vaginally a living unborn child before killing the unborn child" to mean deliberate and intentional delivery into the vagina of a living child or a substantial portion thereof for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child. I think it is very clear now, as we've indicated in previous discussion on Select File, that this means that you have to have intent, so those issues revolving around miscarriage are cleared up in this particular . . . with this particular further definition. Section 3 of the amendment eliminates or preserves, excuse me, Section 3 preserves a physician's judgment to take any medically necessary steps to save the life of the mother

by removing that no other medical procedure would suffice for that purpose, another area that we had discussion on previously Select File that I believe should be acceptable to the opponents. And then the last section gives the . . . gives any accused physician the right to have his or her conduct reviewed by the Health and Human Services Director of Regulation and Licensure before a criminal trial commences. It indicates that he can go in and ask for a delay in the criminal trial until after the review by the Health and Human Services Director of Regulation and Licensure occurs. I would also like to draw your attention to another statement by the AMA which further indicates their support. Everyone will recall we've had discussion as to whether or not where physicians were. There has been, of course, the Physicians' Ad Hoc Coalition for Truth that have indicated very strongly that this procedure is not needed. In fact, their position is it's not medicine. The AMA now, through their legislative [p. 7761] process, are supportive of banning the partial-birth abortion. Paragraph two: "HR 1122", which LB 23 mirrors, "now narrowly defines the procedure to be restricted – a procedure for which AMA's expert panel could not find any identified situation in which it was the only appropriate procedure to induce abortion – and it broadens the exceptions." The changed language is in the bill now: "makes it clear beyond any question that the accepted abortion procedure known as dilation and evacuation, also referred to as D & E, is not covered by the bill; (b) permits the procedure to save the life of the mother without any obligation to show that no other procedure would suffice; and (c) does not restrict use of the procedure for physicians intending a delivery at the

outset." It can be done as necessary in their best medical judgment. Further in their statement, to clarify their position and support of the ban on partial-birth abortion: "As amended, HR 1122 is now a bill which impacts only a particular and broadly disfavored, by both experts and the public, abortion procedure. It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development." AMA's position goes on: "Indeed, the procedure differs materially from other abortion procedures which remain fully available, in part because it involves the partially delivered body of the fetus which is outside of the womb." Their statement continues: "HR 1122 is serving as a model for many state legislatures and is vitally important that the improvements which have been made become a part of the broader legislative process." And so that's why, with the . . . my staff's help, others' help, we have brought this amendment to you this evening to start the continued discussion on LB 23. I appreciate Senator Kiel's willingness to let a substitute because I think this, in fact, provides I believe needed clarification and hopefully will make the bill more acceptable to those that have not decided up to this point in time whether they can be supportive of LB 23.

SENATOR CROSBY: One minute.

SENATOR MAURSTAD: Thank you, Madam President. The . . . my last discussion I know that there, from what's occurred in earlier discussion, that there will be some that think that this language has already been offered. I would indicate that [p. 7762] there's certainly been discussion about more clearly defining it. Quite

frankly, when I heard that the AMA had some conditions I was skeptical as to what . . . what that was going to actually be presented. I was pleased to find that they've taken a very reasonable approach. I think it was reasonable for the Senate to include it in the bill that they adopted today, although three votes of veto-proof, and I think it's important that we include it in LB 23 and would ask the membership to support Amendment 2325. It also had a number of other cointroducers: Senator Hilgert, who prioritized the bill; Senator Witek prioritized the bill; Senator Brown, . . .

SENATOR CROSBY: Time.

SENATOR MAURSTAD: . . . who had a amendment that we adopted earlier on Select File. Thank you.

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[p. 7766] SENATOR CHAMBERS: Mr. President and members of the Legislature, I had said that Senator Maurstad is getting his orders from Washington, D.C. He needed to have those "Repelicans" in Congress tell him that issues that were raised here are all right to be added to this bill. He's not changing this bill because he has thought it through and has become convinced of anything. He is following their dictates, and you can see it from the language that he selected. It's what Congress, what the Senate today adopted. That's why he comes with this amendment. And he did make one difference in the terminology and I guess that's to show his independence. One of them says partially vaginally delivers; the other says partially delivers vaginally. Now if there is any meaning to be derived from the order in which words occur, then they're not talking about the same thing or

they're not saying the same thing about the same issue the same way. But, again, since they're following the lead of the people in Washington and feel like they've done something here, it's their bill. I still think it is an [p. 7767] atrocious piece of legislation in terms of the drafting, even if you get away from some of the other aspects of it. One of the things that I am still offended by is the fact that they do not want to acknowledge that a woman's health is important to be preserved. Since they are talking about something that they say should never happen anyway, I don't see why Senator Maurstad and others would have any objection to including language about the impairment of a vital organ of the mother-to-be. But they haven't been told that's it's all right to do that. If they had been told that it was all right to do that, it would be done. I have handed around an article to show you that in the context of the AMA's position the article talking about, and they put it in quotation marks, this partial-birth abortion, as these religious and other people characterize it for the purpose of cluttering up the statute and getting their particular view into the statute, the part that I marked is in this sentence, and it's talking about the AMA Board of Trustees: The board said in a 35-page report that there is "no identified situation" in which such abortions known medically as intact dilation and extraction, is the "only appropriate procedure." What I'm showing you is where they say "known medically". Senator Maurstad has not been told that that's how the term is known medically, so he says it's not. Well, fine. That's like when they say the earth if flat, then it's flat because they said so. But again going to Sir Thomas Moore when, they were trying to make him say something but his was

under pain of losing his head, make him say something that he didn't think was true, asked his interloctors if I say the earth is round it is no less round because the king says it's flat.

SENATOR BRASHEAR: One minute.

SENATOR CHAMBERS: And if the king says it is flat, it is not flat simply because his fiat said it is. So because Senator Maurstad and other narrow-viewed people on this floor want to tell us what is and is not a medical term, despite what the medical community has said, their disavow does not make what they say so. These terms ought to be changed. I've told Senator Maurstad after I'd offered two amendments on Select I wouldn't offer any more there, but on Final Reading, and he knows this, I'm going after this bill and there are a lot of objectionable terms I find in it and I'm going to see if we can [p. 7768] reach an accord on some of them. But in the meantime, I'm opposed to his definition because I do not think it is accurate.

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[p. 7770] SENATOR CHAMBERS: Mr. President, members of the Legislature, if what Senator Maurstad is doing is a sincere attempt made in good faith to tighten the language in this piece of legislation and bring clarity, there should be no objection to using the term "intact dilation and evacuation". It's simply that those jerking his chain did not tell him he could use those terms. That's all this is. He admits he's not a lawyer. I know he's not a lawyer, but he's not a lawyer on these other matters either, but he's been told that they are all right to be adopted and the Legislature's going to follow

suit. When we get to Final Reading I'm going to . . . I'm going to have my amendments drafted. All of this talk of an unborn child, now when I read the information put out by the Right-To-Life people, they use the term "fetus". In the legislation that the Senate passed, they use the term "fetus". This unborn child business is designed to convey a religious point of view. It is not used in the medical profession. Senator Maurstad cannot show any medical literature where that it was is used and he cannot show other states it's here because it was during a particular period when I think Senator Labedz was the one who wanted that in there more than anything else. So I'm going to try to clean this language up and maybe the Legislature will not agree to do it, but I will make a record of all the places in the existing abortion statutes which misuse language, which uses words and phraseology which have no medical meaning or validity, but rather are designed to show the contempt, hatred and disgust these people of their religious persuasion feel toward a woman who sees the necessity to have an abortion. It is nobody's business other than the woman and her medical care provider as to whether or not she'll carry a pregnancy to term. All this meddling, all this intrusion by the state is totally [p. 7771] unwarranted. And everybody may feel good here this evening because they think they've got the bill in a condition where there doesn't have to be any discussion and we can get on out of here. That will not work with me. I am as alive to the wrongfulness of this bill at this late hour, this late in the session as I have ever been. When I come here I'm prepared to deal with every issue that I think needs to be addressed, and although I was working all day long on

various pieces of legislation, we had some very emotional and heated exchanges, but that in no way diminishes my energy or my consciousness of my responsibility and obligation to fight against badly drafted, badly intended legislation. This is not good legislation. It is not necessary. But if the Legislature is intent . . .

SENATOR BRASHEAR: One minute.

SENATOR CHAMBERS: . . . on doing it, there should at least be enough honesty to admit where it came from and why it's taking the form that it's taking. This is not a result of deliberate thought, deep consideration and finally an arrival at the conclusion that these changes ought to be made. Just like marionettes, when the one who controls him told him what to do, he said bark, they bark; he said bite, they will bite; he says roll over and play dead, they roll over and play dead. Not I. Not I.

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[p. 7778] SPEAKER WITHEM: You've heard the closing. The question now is the adoption of the Maurstad amendment to LB 23. All of those in favor vote aye, opposed vote nay. A record vote has been requested. We are now voting on the adoption of the Maurstad amendment to LB 23. Have all members who wish to record their vote voted? A record vote has been requested. Mr. Clerk, please record.

CLERK: (Record vote read. See page 2160 of the Legislative Journal.) 29 ayes, 2 nays, Mr. President.

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[p. 7780] SENATOR CHAMBERS: Senator Maurstad, as I look at this legislation that is the Senate

bill where they are acting on HR 1122, I see on page 2 of that bill where this language is stricken: provided that no other medical procedure would suffice for that purpose. And what I see you striking from the bill is, "and no other medical procedure would suffice for that purpose". Why does this seem reasonable today after the Senate has acted when it didn't seem reasonable the last time we discussed this bill?

SPEAKER WITHEM: Senator Maurstad, would you respond?

[p. 7781] SENATOR MAURSTAD: Yes, I would, Mr. President, if I could take just a moment to take . . .

SENATOR CHAMBERS: Sure.

SENATOR MAURSTAD: . . . elaborate just a moment. Senator Chambers, as you're aware, I've stated on a couple of occasions the . . . where I derived the reason for the introduction of this bill in the first place. I have been very up front about that. I indicated that my original draft, that has been changed by the committee amendment, was in effect the . . . what was adopted last year by the House and the Senate, and I have felt that once it has gone through the scrutiny that is available at the federal level and you have a majority of both houses supportive of it, then after I, of course, read it, analyzed it and felt comfortable with it, that's what I used as a starting point. Once again, I think that, as always in legislation, as you've exemplified on a couple of occasions, there is always a compromise to be made if there is a reason and if it can help move a bill along. That would be my explanation to you; that this has been a concern that was raised by the American Medical Association,

who previously had been neutral on the issue, they raised this issue. It was agreed upon by those that are working on this issue at the federal level. Because, I'm taking . . .

SENATOR CHAMBERS: Okay, but my time . . .

SENATOR MAURSTAD: . . . as I indicated before, I'm more than willing to indicate that I would take their advice.

SENATOR CHAMBERS: But the fact that the Senate struck this language is really what led you to strike it, isn't that true? And the fact that they included other language which you practically verbatim have put into this bill, isn't it what the . . .

SENATOR MAURSTAD: It . . . it is . . .

SENATOR CHAMBERS: . . . Senate did that brought us to where we are today on these amendments?

[p. 7782] SENATOR MAURSTAD: It would be . . . it would be twofold. It would be the willingness of the American Medical Association to offer what they feel and their membership feel is an improvement . . .

PRESIDENT ROBAK PRESIDING

PRESIDENT ROBAK: One minute.

SENATOR MAURSTAD: . . . to the bill and the Senate's acceptance of it.

SENATOR CHAMBERS: Senator Maurstad,the Medical Association will not use the term "partial-birth abortion", but that's any good. Their judgment on that is not good, is it, because they don't know anything about medical terminology? Would you agree with that?

SENATOR MAURSTAD: No, Senator, as I indicated before, I punched my light on, I don't know if there are other lights are on, but the language that you wanted to use is also not a medical terminology. It is also not an approved medical procedure; and so what we're using as partial-birth description is one that, through the bill, can be easily understood and interpreted by those that need to look to this for direction.

SENATOR CHAMBERS: If it's easily understood, why did you add that additional language to the definition that the Senate put in it? You told us the other day, that it was crystal clear and I pointed out how vague it was, so today you come in with changes. Now it was not that clear the other day, as you thought, . . .

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[p. 7784] SENATOR CHAMBERS: I was trying to see who's paying attention. And they pause. They weren't sure. When Senator Lindsay was here, he wasn't dictated to by the lobby or Washington, D.C., nor was Senator Hall. If they felt that an amendment had validity there was no argument about it. There'd be discussion and when they were persuaded it could be adopted. The last time I spoke, just before Senator Schimek lit into me, justifiably from her point of view, I was talking about that definition that was in the bill before the Senate told Senator Maurstad that he could change the definition here. I gave detailed explanations of why that definition was inadequate. He said it's inadequate (sic), everybody can understand it, it's clear, just [p. 7785] read it. Well, if that's true, why did we have one, two, three, four, five, six, seven additional lines of definitional material? Not

because the definition was less clear to Senator Maurstad then than it is now. He didn't have permission to consider anything else. Senator Maurstad, I had explained earlier why the term "unborn child" is in the statute. It has nothing to do with medical terminology. It's a religious position and they wanted to put it in the statute, and they had the votes to do it so the statutes are cluttered just like our constitution has been defiled. But I'd like to ask you a question. On page 3, we see the term "living unborn child". Those three words are not coherent to me. They're unintelligible. What does that mean, "living unborn child"?

SENATOR MAURSTAD: That means a child that is not dead and not born.

SENATOR CHAMBERS: So before a being comes into this world, that is a child? That's a child, is that correct?

PRESIDENT ROBAK: One minute.

SENATOR MAURSTAD: Excuse me?

SENATOR CHAMBERS: That which is still in the womb is a child, according to your understanding?

SENATOR MAURSTAD: I think it can be. . . . Yes, it can be referred to as a child.

SENATOR CHAMBERS: Is that what madison . . . is that what medical people call it. Senator Maurstad?

SENATOR MAURSTAD: I think that there are medical people that would call it that, yes.

SENATOR CHAMBERS: When they're discussing this in medical terms, is that what the bill that the House passed and the Senate acted on today, do they call it an unborn child?

SENATOR MAURSTAD: Yes.

[p. 7786] SENATOR CHAMBERS: Do they?

SENATOR MAURSTAD: I believe so, but I can double check it, sir.

SENATOR CHAMBERS: This will give you a chance to correct me.

SENATOR MAURSTAD: They refer to it as a "living fetus".

SENATOR CHAMBERS: So they don't call it a child?

SENATOR MAURSTAD: No.

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[p. 7795] SENATOR CHAMBERS: And now here is what I would like to ask you about this definition, and I'm looking in your amendment, page 3 of your amendment, line 20, unborn child or a substantial portion thereof. What is a substantial portion of an unborn child? And that brings us back to where we were the other day when you couldn't tell me what "partially" meant. What is a substantial portion?

SENATOR MAURSTAD: Senator Chambers, a substantial, as a definition, is I would say a great deal of.

PRESIDENT ROBAK: Time.

SENATOR MAURSTAD: A lot of.

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[p. 7808] SENATOR CHAMBERS: Senator Maurstad, sometime back I didn't get to complete my discussion with you about what is the meaning of the terminology in line 20 of page 3 of your amendment talking about what you all refer to as unborn child, and then we have the language " . . . or a substantial portion thereof". We're talking about the substantial portion of an unborn child, is that true?

SENATOR MAURSTAD: Yes, sir.

[p. 7809] SENATOR CHAMBERS: Okay, now in trying to get to the meaning of "substantial", you said, a lot, and what else, basically, did you say it means?

SENATOR MAURSTAD: Well, if you'd like, I knew we were running out of time, Senator, so I tried to be concise. If you'd like, I can spend a couple of more moments and maybe provide a better . . .

SENATOR CHAMBERS: It wouldn't take a lot of moments is it, let me ask it, is it one-third, is that a substantial portion?

SENATOR MAURSTAD: Substantial portion, one-third.

SENATOR CHAMBERS: Not sure, really, are we?

SENATOR MAURSTAD: Yes, I think it would be a substantial portion.

SENATOR CHAMBERS: One-fourth, which is less than a third. Is that substantial? It's not really clear, is it?

SENATOR MAURSTAD: I want . . . I want . . . I don't want to be flippant, but I would say, it would depend upon . . .

SENATOR CHAMBERS: Go ahead and answer it, really.

SENATOR MAURSTAD: It would depend on which fourth.

SENATOR CHAMBERS: I understand, but, nevertheless, if you looked at one portion and somebody else at another, they might arrive at a different conclusion as to whether one-fourth is a substantial portion, do you agree?

SENATOR MAURSTAD: Yes, substantial would be subjective.

SENATOR CHAMBERS: And isn't it necessary, and if you read the AMA letter, to let people know precisely what is being banned or being prohibited, the crimi . . . oh, that's all I will ask you because you might want to put on your light and go into it with . . . at greater depth than we can now because I want to make a [p. 7810] statement. When you have, as a part of the definition, a term which is susceptible of differing meaning to reasonable people, you have an ambiguity. An ambiguity means that this that you're looking at could mean one thing or another or neither of those but a third thing. And what is substantial to one person is not substantial to another. And as Senator Maurstad pointed out,

and it might have sounded flippant but it really wasn't, it depends on what portion it is. Does it mean substantial in terms of being essential to having a full-fledged human being, or does it mean simply quantity? Does it mean, instead of portion, percentage, and then you still have the same problem? It means different things to different people, and I think that, again, creates vagueness, ambiguity, and since we're talking about a criminal statute, and we are defining here the elements, then it cannot stand, and that is the contingent that I'm making. Section, the portion that I'm trying to strike, subdivision (15) of Section 28-340, no, no, 71-148, refers us back to the language of this definition. This language . . .

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: . . . is also referred to when we talk about these criminal proceedings against the physician, but when you go back to the fountainhead or the definition, there is ambiguity, and that is enough to bring the whole thing down, and I don't want Senator Maurstad to accept what I am saying. I want him to leave this language just like it is. But if you ask two people what does "substantial portion" mean, they'll give different answers. Senator Maurstad is like this guy who is being questioned on the witness stand because an individual had been struck on the head with a projectile. And the prosecutor was asking the witness, what . . . what . . . how large was this projectile? The guy said, oh, it was . . . it was largish. He said, well, that doesn't help me, I mean how big was it? He said, well, it had bigness. He said, now what does largeness and bigness mean?

PRESIDENT ROBAK: Time.

SENATOR CHAMBERS: He said, oh, about the size of a lump of chalk. And when he got through, nobody . . .

[p. 7811] PRESIDENT ROBAK: Time, Senator.

SENATOR CHAMBERS: . . . still knew.

PRESIDENT ROBAK: Thank you, Senator Chambers. Senator Maurstad.

SENATOR MAURSTAD: One aspect of the discussion, Madam President, to carry forward what Senator Chambers is somewhat alluding to, and one of the things we need to keep in mind is under the description of a partial-birth abortion by Dr. Haskell, who is the one that provides the definition and the description and the way to go about performing the partial-birth abortion at a seminar, he talks about the physician physically turning the unborn child inside the uterus of the mother so that the child can be, in essence, put in a position where it would be classified as a breech delivery. And so the understanding here is that, first of all, we're putting the mother at risk by doing this. It is not a procedure that is . . . that is not even recommended, it is not recommended to be done, but we turn that child and we . . . and for to perform a partial-birth abortion and bring the unborn child into the vagina from the uterus in the breeched position. So what we're talking about here is a substantial portion of that child would be not in the uterus, passing through the cervix into the vagina. Now the reason that it's done is so that this procedure can be performed, because the cervix is not dilated to the point where the head could proceed through. In fact, the doctor indicated that you would not want that to occur because

then a live birth would happen, and that is not the intent of a partial-birth abortion. So we have to go back to look at the words "substantial portion" within the context of the whole definition, and in the context of what the procedure is defined to be and is known to be. So I think that it is very clear what substantial portion thereof would be when this procedure is taking place, once again, deliberately and intentionally. I think it's important. I have passed out the letter from Deb Thomas, the Director of Regulation and Licensure, and upon her recommendation included this section. I believe it was included in the committee amendment. It was not included, it was not a part of my original bill, but was a part of the committee amendment in the work that the committee did, and so they have drafted it in a [p. 7812] manner that is proper and appropriate. And, as such, I think it is not correct to do what Senator Chambers would ask us to do, and that is delete this section, and so I would, once again, urge my colleagues to vote against the Chambers amendment. Thank you, Madam President.

PRESIDENT ROBAK: Thank you, Senator Maurstad. Senator Chambers.

SENATOR CHAMBERS: Madam President, members of the Legislature, I would like to ask Senator Maurstad a question, because he said something that is kind of amusing to me.

PRESIDENT ROBAK: Senator Maurstad.

SENATOR CHAMBERS: Senator Maurstad, when . . .

SENATOR MAURSTAD: Sir, did I intend to be amusing?

SENATOR CHAMBERS: . . . we were talk . . . huh?

SENATOR MAURSTAD: Was it one of those moments when I was intending to be amusing?

SENATOR CHAMBERS: Well, I am not going to use my psychic powers and determine what you intended, but it could have been an unintended effect. But were you saying that while we're talking about the definition of substantial portion that Dr. Haskell, whoever that is, said that you rotate the fetus into a position approximating that of a breech birth and so forth? You had said that's what Dr. Haskell said in saying what this term, . . .

SENATOR MAURSTAD: That was his description, yes.

SENATOR CHAMBERS: . . . partial-birth . . . okay, so then this definition, shouldn't we amend it to say, all of these other things about what a partial-birth abortion means, and when we get to the final period add, or ask Dr. Haskell, as a part of the definition?

SENATOR MAURSTAD: No, no, we shouldn't do that, Senator.

[p. 7813] SENATOR CHAMBERS: Oh, and I know that, but to have a complete definition, you saw the necessity to include what Dr. Haskell said because the language of the definition, itself, is inadequate to the purpose. Isn't that true?

SENATOR MAURSTAD: No, I was trying to answer a question that you had . . . that you had raised, and because of that, I was trying to elaborate to the point that you would more easily understand. I think it is understandable as it . . . as it's written and doesn't need to be . . . doesn't need to be expanded any more.

SENATOR CHAMBERS: Now, there is nothing in this language that says that the fetus has to be emerging from the womb or the vagina feet first, is there? There is nothing that says that, is there?

SENATOR MAURSTAD: No, there isn't.

SENATOR CHAMBERS: In the procedure known as intact dilation and evacuation, it is understood that the fetus would be emerging feet first, isn't it? Isn't that what would be understood by that term? Come on, be level with me.

SENATOR MAURSTAD: Yes, sir. Yes, sir.

SENATOR CHAMBERS: Is it? Okay.

SENATOR MAURSTAD: Yeah, I'm just . . . I want to make sure I give the correct answer.

SENATOR CHAMBERS: Okay.

SENATOR MAURSTAD: And so . . . I just paused a moment to reflect is all.

SENATOR CHAMBERS: Okay, now that you've reflec . . .

SENATOR MAURSTAD: Yeah, yes, yes.

SENATOR CHAMBERS: Okay, so if we used intact dilation and evacuation, we know that that means

the fetus is emerging feet first. When you say partial-birth abortion, it doesn't say [p. 7814] which portion, substantial, whatever that means, is emerging from the vagina. So we have two different concepts here. The definition does not say what Senator Maurstad wants it to say. There is nothing in his legislation that lets you know what it is this definition is dealing with except that a substantial portion of the fetus has emerged. And we don't know what substantial portion means, and we don't know whether it was head first, feet first, or whatever. Senator Maurstad, can an intact dilation and evacuation procedure, or as you call it, partial-birth procedure occur if the head emerges first? If the head emerges first, can there be a partial-birth abortion, as you defined it?

SENATOR MAURSTAD: Yes.

SENATOR CHAMBERS: Right. With intact dilation and evacuation, the head cannot emerge first, isn't that correct?

SENATOR MAURSTAD: No.

SENATOR CHAMBERS: Okay, so there can be an intact dilation and evacuation . . .

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: . . . without the head . . . I meant, with the head emerging first? That's what I'm asking. If the head emerges first, can you have an intact dilation and evacuation . . .

SENATOR MAURSTAD: I would . . . I would . . .

SENATOR CHAMBERS: . . . if the head emerges first?

SENATOR MAURSTAD: . . . say, I think anything is possible in that respect.

SENATOR CHAMBERS: No, you can't, not by what this term means. What this term means is that procedure that you've been describing where the feet emerge first. But by your definition, the head can emerge first and you have a partial-birth abortion. The feet can emerge first and you have a partial-birth abortion. The baby, as you want to call it, can come out sideways, if it's [p. 7815] small enough, and you can have a partial-birth abortion. All you need by your definition is for a substantial portion to emerge. Isn't that true under your definition?

SENATOR MAURSTAD: Not just that. You also have to have the deliberate and intention of putting that unborn child into the vagina . . .

PRESIDENT ROBAK: Time.

SENATOR MAURSTAD: . . . with the purpose of killing the unborn child.

PRESIDENT ROBAK: Thank you, Senator.

SENATOR MAURSTAD: You have to have that also.

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June 2, 1997 LB 23

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[p. 9209] SENATOR KIEL: Thank you, Mr. President and members of the Legislature. I have indicated in the past that I have a lot of concerns about this bill, but I want to speak to one issue with regard to the language in this bill. I think probably this legislation is on . . . purposely drawn broadly and imprecisely. It uses terms not recognized by the very constituency, and that is physicians whose conduct the law would criminalize. It fails to distinguish between natural and induced pregnancy termination, which we have spoken to this evening, or between different stages of gestation. It purports to address a single procedure, some elements of which are used in other areas, OB-GYN, but it doesn't carefully define that procedure. Finally, it doesn't limit its scope to techniques performed after fetal viability, and I think that's a real serious problem. And that potentially affects procedures at all stages of pregnancy. I'd call your attention to the language that says viability means that stage of human development when the unborn child is potentially able to live more than merely momentarily outside the womb with the mother by natural and artificial means. I think the . . . we have a serious problem with the language in that potentially it does not particularly have a definition, and momentarily doesn't particularly have a definition either. The bill might be interpreted or enforced to include the results or procedure needed to

drain excess fluid in the brain of alive hydrocephalic . . . well anyway, fetus during the course of delivery when spinal fluid is drained in a manner resulting in fetal death. Zealous enforcement could arguably extend to cases of incomplete spontaneous abortion where the removal of the fetus is accomplished by the same techniques as an induced abortion or to many other gynecologic or obstetric procedures where the fetus is living when the procedure begins. My biggest concern is that this will be interpreted or enforced beyond a specific technique of endorse . . . induced abortion. A political discussion has reflected a lot of confusion about medical terminology and technique, and the likelihood for misinterpretation or deliberate misinterpretation is high. This law would have a [p. 9210] chilling effect on the practice of medicine, leaving doctors with an understandable fear of prosecution to avoid medical procedures or surgical techniques that could in any way fall within the scope of such legislation. I think the impreciseness, the broadly defined language in this legislation is a real problem. And with that I would yield the remainder of my time to Senator Chambers.

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[p. 9217] SENATOR CHAMBERS: Senator Maurstad, wherever the fetus is spoken of as being alive, in the definition for one place and there may be other places in the bill, that doesn't mean that the fetus is breathing does it?

SENATOR MAURSTAD: Senator Chambers, are you in Section 1?

SENATOR CHAMBERS: Yes, but . . .

SENATOR MAURSTAD: Okay.

SENATOR CHAMBERS: . . . I want to find out when we use the term "alive" or "living", does that mean that the fetus is breathing, the unborn fetus?

SENATOR MAURSTAD: Well, it's my understanding that the fetus is alive and is breathing and is on the support of the mother through the umbilical cord.

SENATOR CHAMBERS: That before it comes into the world it's breathing? I'm just asking for your understanding.

SENATOR MAURSTAD: Yeah. From my perspective, I would think that the . . . it would be breathing, yes.

SENATOR CHAMBERS: Thank you: I'd like to ask Senator Dierks a question. Senator Dierks, is a fetus breathing when it's in the womb?

SENATOR BRASHEAR: Senator Dierks, will you yield?

SENATOR DIERKS: It is not breathing as you and I call breathing. It's just living on the blood of its mother.

SENATOR CHAMBERS: Thank you, but . . . and there might be an exchange of oxygen by way of the blood, but there is no breathing.

SENATOR DIERKS: That's right.

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[p. 9231] SENATOR CHAMBERS: And the words "or a substantial portion thereof".

SENATOR MAURSTAD: Yes.

SENATOR CHAMBERS: Now, does it mean that the person deliberately and intentionally delivers into the vagina or a substantial portion of the vagina this unborn child? What does "or a substantial portion thereof" refer to?

SENATOR MAURSTAD: The substantial portion . . . I think it's . . . I believe that the "substantial portion thereof", in fact, refers to the living unborn child.

SENATOR CHAMBERS: And again, because we went through this before you use substantial, we don't really know what substantial means, do we?

SENATOR MAURSTAD: Well, we discussed that on Select File and . . .

SENATOR CHAMBERS: And we don't know any more on Final than we knew on Select, wouldn't you agree?

SENATOR MAURSTAD: Well, I think I know the same thing I knew on Select File that substantial is easily defined and would not be something that would be necessarily contestable.

SENATOR CHAMBERS: Well, then would you define it for me in the easy manner that it can be done in an incontestable manner?

SENATOR MAURSTAD: Well, I think substantial would indicate that more than a little bit has been delivered into the vagina. I [p. 9232] don't mean to be flippant. I'm just trying to be as honest as I can in my interpretation of what substantial would be.

SENATOR CHAMBERS: How much is a little bit because we . . . we're . . . more than that?

SENATOR MAURSTAD: Well, enough . . .

SPEAKER WITHEM: One minute.

SENATOR MAURSTAD: Enough that would allow for the procedure to end up with the killing of the unborn child.

SENATOR CHAMBERS: So then, that means the fetus could be coming out head first, right?

SENATOR MAURSTAD: That certainly could be the case and it could, at that point, delivery stopped and either the child dismembered or the child be killed in the manner that I spoke of earlier.

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[p. 9236] SENATOR CHAMBERS: Okay. I could read the whole definition, but I'm going to start in line 12 where it tells us what this means, and I'm starting with the word means, " . . . means deliberately and intentionally delivering into the vagina a living unborn child or a substantial portion thereof". What does, for the purpose of a criminal statute's precision, do the words "or a [p. 9237] substantial portion thereof" mean?

SENATOR BRASHEAR: I believe it would be substantial in terms of physical . . . I'm hunting for a word . . . physical form or physical function so that we would be talking about the head or the chest area. In other words, it's something more than a foot or a hand.

SENATOR CHAMBERS: Could it be a leg?

SENATOR BRASHEAR: I think not because that's what I was trying to say, and probably not very articulately, I think "substantial portion" would apply both to the portion of the body and to the function of that portion of the body.

SENATOR CHAMBERS: But you would agree with me, I'm sure, that the language of the definition does not say that.

SENATOR BRASHEAR: That's correct.

SENATOR CHAMBERS: Don't you agree?

SENATOR BRASHEAR: That's correct.

SENATOR CHAMBERS: And two judges may look at it and arrive at different conclusions as to what that means, would you agree with that?

SENATOR BRASHEAR: There's no question there will be a fact question as to what is a substantial portion.

SENATOR CHAMBERS: And when you're talking about the definition of the element of a crime, isn't is necessary that the person who runs the risk of being charged with it has to know in advance and with precision what is prohibited and what is permitted? Isn't that the standard requirement of all criminal statutes?

SENATOR BRASHEAR: Yes, but with all due respect, Senator Chambers, I think you are, in being efficient, you're taking on a very narrow portion of the phraseology because in applying this as a criminal statute, there's going to be the concept of [p. 9238] "delivering into the vagina a living unborn child; or a substantial

portion thereof, for the purpose of performing a procedure that . . . "

SENATOR CHAMBERS: But you . . .

SENATOR BRASHEAR: So you're going to get into the question of, could the procedure have been performed on the head? Yes. Could the procedure be performed on the arm . . . the arm and wrist or hand and wrist? No.

SENATOR CHAMBERS: Well, you could cut the veins, but here's the thing, Senator Brashear. The part of the definition that all the rest of it is keyed to is that a "substantial portion thereof" was delivered into the vagina. And that's all I will ask you, by the way, and thank you for your help. The fact that we disagree and that Senator Brashear has to explain it indicates that it does not have the precision a criminal statute needs, and I'm glad he said that I am taking a very narrow view or narrow construction. The Supreme Court has said repeatedly, any statute in derogation of the common law is narrowly construed, and criminal statutes are in derogation of the common law. Anytime you codify something by statute, you . . . that is derogating from the common law, and that's why all . . .

SPEAKER WITHEM: One minute.

SENATOR CHAMBERS: . . . criminal statutes are narrowly construed. No more will be read into what the words actually say. And if by reading these words in the narrowest manner possible, it is unclear what they

mean and reasonable people can differ, then it is unconstitutionally vague. So I'm sure that that cannot pass constitutional muster.

SPEAKER WITHEM: Senator Chambers, you would now be recognized to close on your amendment.

SENATOR CHAMBERS: Thank you, Mr. Speaker. And this portion of this bill is extremely important, and, Senator Brashear, as was done with the term limits bill and the things that were gotten into the record that the court made reference to, I want to make it very clear what I'm saying about this language. Let me ask [p. 9239] you this one question, then I will release you on this aspect of it. Would you agree that if this definition is struck down as unconstitutionally vague or ambiguous, the whole act would fall? If . . .

SENATOR BRASHEAR: I'm thinking, Senator Chambers.

SENATOR CHAMBERS: If the definition falls, the whole act, which depends on the definition, must fall also. Isn't that true?

SENATOR BRASHEAR: Yes, I would think so.

SENATOR CHAMBERS: Okay, thank you. And Senator Maurstad helped show how vague this definition is. Senator Brashear helped show how vague it is. He's even including function, yet there's nothing in the definition that talks about a function of the portion that is delivered into the vagina. The only thing that this bill says about the portion is that there must be . . . it must be substantial. It doesn't say the head, it doesn't say one leg, two legs. What it happening here is that Senator

Maurstad and maybe others are envisioning what the term "partial-birth abortion" means to them, so when they read these words, in their mind they conjure up a picture of the fetus being extracted feet-first, but that's not what the amendment says. The amendment doesn't say head-first, feet-first, or sideways. Let me ask one question of Senator Maurstad. Senator Maurstad, there is nothing in this bill that speaks of the time, the stage of development of this fetus, is there?

SPEAKER WITHEM: Senator Maurstad, can you respond?

SENATOR MAURSTAD: No. Yes. No, there isn't, Senator.

SENATOR CHAMBERS: So it could be in the first trimester?

SENATOR MAURSTAD: Yes.

* * *

[p. 9243] SENATOR CHAMBERS: Okay. Now, if we go further down into line 24, this evidence . . . well, I guess you'd have to go up to line 20. Whether the attending physician's conduct was necessary to save the life and the mother and so forth. "What is developed at that hearing shall be admissible in the criminal proceedings brought pursuant to this section." Do you believe that in order for that which is produced at that hearing to be admissible, it would have to have been given under oath? Do you think, in other words, statements made which are not under oath would be admissible in the criminal proceeding?

SENATOR BRASHEAR: I do not, Senator Chambers, but that's not what the reference here is. The reference here is to the findings of the director.

SENATOR CHAMBERS: I know.

SENATOR BRASHEAR: And I believe, administratively, that can be made admissible.

SENATOR CHAMBERS: But here's what I'm asking you, if the findings of the director are based- . . . because we can say anything we want to in a statute, but the constitutional analysis will be based on whether or not that which we put in statute measures up [p. 9244] to the constitution. If findings by the director were based on statements not taken under oath, you believe that those findings would still be admissible?

SENATOR BRASHEAR: I believe that they could and would be, but I understand the issue you're raising and I am not a member of the court.

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June 3, 1997 LB 23

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[p. 9393] SENATOR CHAMBERS: . . . you looked at this definition in this bill? It would be found on

page 4. I will read it to you, the part that is significant. That what is being defined is this string of words: "partially delivers vaginally a living unborn child before killing the unborn child". That's what's being defined, and this is the definition. Those words mean "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof". What does "substantial portion thereof" mean, in your opinion? First of all . . .

SENATOR ABBOUD: Which . . . which line is that on, Senator [p. 9394] Chambers?

SENATOR CHAMBERS: Lines 13 and 14, on page 4. Toward the end of the line we see "or a substantial portion thereof". What does that mean?

SENATOR ABBOUD: Well, I think that's . . . I don't think that's probably defined in . . . anywhere else in statute and may be defined some place in case law with some . . . some other . . . maybe some court cases have defined what that particular language means. To me, speaking without the benefit of knowing how other courts have defined it, I would assume it would be a substantial . . . "substantial" would mean a significant portion of that child.

SENATOR CHAMBERS: And what does "significant" mean?

SENATOR ABBOUD: I really couldn't give a definition to that beyond what I've given, Senator Chambers.

SENATOR CHAMBERS: Nor can I, so don't think that I've got an answer. If you were representing a

client and your client had to face an indictment or an information or a complaint which accused him or her of this . . .

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: . . . offense and included in that document charging the offense was this language, "or a substantial portion thereof", would you, as the defense attorney, know what you were being asked to defend your client against in terms of "a substantial portion"? Could you say that there was not a substantial portion since nothing tells us what that means?

SENATOR ABBOUD: I would think that . . . I really wouldn't know the answer to that, Senator Chambers, about . . . to see if there'd be some . . .

SENATOR CHAMBERS: Well, let me ask this question.

SENATOR ABBOUD: I would . . . I'd be willing to say, I don't know if you've talked to the sponsor about this particular issue, but [p. 9395] the . . . I assume the language was drawn in such a manner to deal with a possible court challenge and maybe . . . maybe Senator Maurstad is the person that could best answer your . . .

SENATOR CHAMBERS: But he's not a lawyer.

SENATOR ABBOUD: Well, he may not give you the answer you want either, so that could be . . .

SENATOR CHAMBERS: Well, he said it means more than a little bit, but that wasn't . . .

PRESIDENT ROBAK: Time.

SENATOR CHAMBERS: . . . very helpful.

PRESIDENT ROBAK: Thank you, Senator Chambers. Senator Maurstad.

SENATOR MAURSTAD: Thank you, Madam President. I move to oppose the motion to return to Select File. As we discussed for a short while last night before we adjourned, this is an issue of clarifying a specific illegal action. It is consistent and not contradictory to other provisions that are in the . . . in this section, subsection (8) for example, the performing, procuring, or aiding and abetting in the performance or procurement of a criminal abortion. This doesn't conflict with that. It's consistent with that. It's a specific reference as opposed to a general reference. It is important relative to the bill and needs to be . . . needs to remain in the statute. I . . . to harken back just a moment to some of the discussion that Senator Chambers is digressing on that we discussed relative to the definition, after the exchange that Senator Chambers just relayed where I indicated what he has reiterated, I also then went back and indicated that in my opinion a foot could be a substantial portion because once that foot comes out it can't be put back and, as a result, that would be, in my opinion, a substantial portion of this child. So, with that, without any . . . I think we did have about as much discussion on this amendment as we had on some of the others last night. I think that we were getting to a point where Senator Chambers may have realized the importance of this and so if I could ask, excuse [p. 9396] me, ask Senator Chambers a question.

PRESIDENT ROBAK: Senator Chambers.

SENATOR CHAMBERS: Yes.

SENATOR MAURSTAD: Senator Chambers, after the discussion we had that last night relative to the clarification on this particular issue, are you considering withdrawing this amendment and moving on to the last one?

SENATOR CHAMBERS: No, because this one would be . . . would hinge on what the definition means . . .

SENATOR MAURSTAD: Okay.

SENATOR CHAMBERS: . . . and so I would want to explore the definition.

SENATOR MAURSTAD: I was unclear as we were . . . as we were ending last night. I may have misinterpreted a comment that you made and so I wanted to clear that up before we went any farther. So, with that, I'll again indicate that I oppose the motion to return the bill to Select File to strike Section 5, which includes the action that would become illegal as a result of LB 23. Thank you, Madam President.

PRESIDENT ROBAK: Thank you, Senator Maurstad. Senator Chambers.

SENATOR CHAMBERS: Madam President, I would like to ask Senator Maurstad a question in view of his elaboration of what "substantial" means.

PRESIDENT ROBAK: Senator Maurstad.

SENATOR CHAMBERS: Senator Maurstad, you said that as small a portion of the fetus as a foot would constitute a substantial portion in your opinion. Is that correct?

SENATOR MAURSTAD: Yes, I believe that's correct. That's what I indicated.

[p. 9397] SENATOR CHAMBERS: So a hand would be the same thing.

SENATOR MAURSTAD: True.

SENATOR CHAMBERS: And those are about the smallest portions of the fetus that could be exposed.

SENATOR MAURSTAD: Um-hum.

SENATOR CHAMBERS: Why then didn't your bill say "any portion" rather than "substantial"? "Any" would be less vague than "substantial".

SENATOR MAURSTAD: Well, I think that . . . I don't agree. We have a disagreement on whether "substantial" is vague or not. I think it is a term that is easily understood and easily interpreted within the context of the balance of the definition and . . .

SENATOR CHAMBERS: But you said it could be a hand or a foot, and Senator Brashear talked about the head or the chest or a part of the body that . . . where vital actions/activities were occurring, so you and he have a different definition of it, so how can you say it's clear and easy to define?

SENATOR MAURSTAD: Well, I don't know that we have a clear difference. From my perspective, I don't know that we do, because if the head was the first part of the anatomy that was not in the . . . let me make sure I get this . . .

SENATOR CHAMBERS: Within the woman, and I'll understand . . .

SENATOR MAURSTAD: Within the woman. Okay.

SENATOR CHAMBERS: . . . what you're talking about.

SENATOR MAURSTAD: Within the woman, then I think that any individual part of the child would be a substantial part, an important part of that child and would fit the description.

SENATOR CHAMBERS: So then you would say an "important" part of [p. 9398] the child just as easily as saying "substantial".

SENATOR MAURSTAD: Senator, I think that it is a possibility that different words could have been used to end up with the same definition. You'll have an opportunity now to . . . chastise is too strong of a word, but once again; we need to harken back that I used as the model for LB 23 that was originally introduced, and I'm sorry for taking some of your time.

* * *

SENATOR CHAMBERS: Okay, thank you. I want to ask a lawyer a question 'cause I. . . . Oh, Senator Bromm is . . . oh, there he is. Senator Bromm, you were a prosecutor, so I want to ask you a question. If you were drafting an indictment, an information, a complaint against a physician for violating this statute and a part of the complaint would have to be a statement of what the person is supposed to have done wrong and you would allege that a substantial portion thereof, referring to an amount of the fetus that had emerged from the woman,

what would that term "or a substantial portion thereof" mean?

[p. 9399] PRESIDENT ROBAK: One minute.

SENATOR BROMM: Okay.

SENATOR CHAMBERS: Even though it's in the language of the statute, what does that term mean? What does "substantial portion" mean?

SENATOR BROMM: Well, I can only tell you what I think and a judge would eventually interpret that, but it would be more than an insignificant portion or a very minor portion. It would be . . . it would be a . . .

SENATOR CHAMBERS: Would it be more than a hand?

SENATOR BROMM: Well, one would think so.

SENATOR CHAMBERS: So then a person . . .

SENATOR BROMM: That's a difficult question to answer.

SENATOR CHAMBERS: So now let's put you in the position of a defense attorney. What would . . . how would you defend your client against this charge crafted in this language, that "a substantial portion of" the fetus had emerged from the woman and that's all you're given, "a substantial portion"?

* * *

SENATOR CHAMBERS: Thank you, Madam President. You can see that Senator Bromm has a different view of what this means, and I'd venture to say everybody who is asked the question would have a different

view. Senator Bromm, you know, not only from your [p. 9400] experience as a prosecutor but in being familiar with the law, that criminal statutes must be precise and unambiguous. Do you agree?

SENATOR BROMM: [illegible]t's correct.

SENATOR CHAMBERS: And a person who runs the risk of having that law apply against him or her must be able to tell from reading the law what is allowed and what is prohibited. Would you agree?

SENATOR BROMM: I would agree with that.

SENATOR CHAMBERS: Do you think that a physician reading this language, and by that I meant these words, "or a substantial portion thereof", will know from that language what is allowed and what is prohibited?

SENATOR BROMM: I think it would be difficult, Senator Chambers. I think their inclination would be simply not to take the risk.

SENATOR CHAMBERS: Now in the first trimester the state cannot prohibit a woman from having an abortion. This amendment, I meant this definition does not designate any point or period of the pregnancy and Senator Maurstad acknowledged last night that it would apply throughout the pregnancy. So if it applies to the first trimester when the state cannot prohibit the abortion do you think that a person could be charged with a crime for performing a procedure defined in the manner this one is if it's during that point in the pregnancy where the state cannot prohibit it or criminalize it? In other words,

this will criminalize an abortion at a period when the Supreme Court has said you cannot criminalize it.

SENATOR BROMM: Well, my, Senator Chambers, I haven't had an opportunity to follow all the discussion . . .

SENATOR CHAMBERS: Okay.

SENATOR BROMM: . . . today, but my reaction is that I think what the bill is attempting to do is to prohibit a procedure no matter what stage of the pregnancy that the fetus is in; that [p. 9401] this procedure is not allowed, and that's the way I understand it.

SENATOR CHAMBERS: Is the fetus always. . . . First of all, what does "alive" mean with reference to a fetus, in your opinion?

SENATOR BROMM: Well, I think that once the fetus has . . . can sustain any viability that it is alive.

SENATOR CHAMBERS: Oh, viability, is different because the way they define that term is that it can live outside the mother independently or with the assistance of whatever they say.

SENATOR BROMM: Um-hum.

SENATOR CHAMBERS: But in the early stages or the middle stages, when the fetus is still within the womb of the mother, is it alive? It's not breathing, . . .

SENATOR BROMM: Well . . .

SENATOR CHAMBERS: . . . but is it alive?

SENATOR BROMM: Well, you know, it depends on what perspective. From my perspective it is.

SENATOR CHAMBERS: Is the life of the fetus always terminated prior to its being removed from the woman.

SENATOR BROMM: In . . .

SENATOR CHAMBERS: . . . at every stage of an abortion?

SENATOR BROMM: At every stage of an abortion?

SENATOR CHAMBERS: Yes.

SENATOR BROMM: I do not know.

SENATOR CHAMBERS: If a fetus, during the early stages of a pregnancy, were removed from the woman and it were still alive, whatever that would mean for a fetus, and it was too small, too [p. 9402] poorly developed to live outside the womb . . .

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: . . . that would be a violation of this statute, wouldn't it?

SENATOR BROMM: Well, I thought that this statute prohibited this procedure that we have heard so much about rather than blanket covering any . . . any other procedures that might be applied in an abortion.

SENATOR CHAMBERS: But because they did not designate any stage of the pregnancy, it applies to every stage, every stage.

SENATOR BROMM: If they use this procedure.

SENATOR CHAMBERS: Well, all you have to do is have, as they say, bring the fetus into the vagina,

remove it, and terminate it. It's not where the feet come out first and the only thing remaining is the head at a late stage in the abortion. This is not a prohibition against late-stage or late-term abortions.

SENATOR BROMM: No.

SENATOR CHAMBERS: This applies throughout and that is . . .

PRESIDENT ROBAK: Time. Thank you, Senator Chambers. Senator Schimek. Senator Schimek.

SENATOR SCHIMEK: Yes, Madam President, members of the body, I would yield my time to Senator Chambers, if he wants it.

PRESIDENT ROBAK: Senator Chambers, do you wish to continue speaking?

SENATOR CHAMBERS: Yes, I thank Senator Schimek for that. What I'm trying to show is the lack of wisdom in crafting state legislation based on a multiplicity of sources, not one of which understands the constitutional law of Nebraska. To discuss a procedure which everybody who has talked about it at the federal level, Senator Maurstad, has discussed it in terms of a [p. 9403] late-term abortion, where all of the fetus is outside the mother except for the head. Then, to use the graphic language of those who support this kind of legislation, the skull is pierced, the contents are extracted, the skull is collapsed, and then the remainder of the fetus is removed from the mother. But that is not what your definition defines. If you called it that ID & E, that would let people know from the term itself what it is you're talking about, but you did not want to use that term so you used

language which is not medical, which is not scientific and called is a partial-birth abortion. You do not designate the stage of the abortion . . . of the pregnancy where this procedure is performed. And it doesn't say anything about which portion of the fetus emerges first. But when all of that discussion was going on in the Judiciary Committee hearing, all of that discussion on Select File, I don't know what they talked about on General File because I was not here, it was a procedure of the kind that I described. Yet, when you pass a bill which you say is designed to prohibit that procedure it doesn't define that procedure at all, and that's why I said the purpose of this bill is to prohibit a woman from having an abortion. That's what it's for. If you look at the definition, it covers an abortion at any point during the pregnancy any time the fetus is not terminated within the womb of the mother, and the reason I say "terminated", we cannot even come to a consensus as to what being alive means when we're talking about a fetus. Those who support this bill call it an unborn child. So if they believe that human life starts at conception and that which is conceived is an unborn child, then a zygote is not a zygote. A zygote is an unborn child. And I defy anybody to get on the Internet or anywhere else and find that as a definition of the uniting of the sperm and the egg, that is an unborn child. No way. But if that's what you're going to say it is, these fertilized eggs that they have frozen, are not those unborn children that are existing in a test tube somewhere frozen solid? It shows how ridiculous legislation becomes when the language is selected to convey a religious message rather than to comply and conform to what is legally necessary.

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: So when we get over here to this portion that I want to strike, where we're talking about dealing with [p. 9404] unprofessional conduct, how are they going to determine that the conduct was professional or unprofessional when they don't even know what the procedure means? They don't even know what it is. And you know why they don't know what it is? Because the definition does not tell us. And if they look at the legislative history, the introducer cannot tell us. I don't know if Senator Bromm is on this bill as a cosponsor but he's a lawyer and former prosecutor. No, he's not on here. Yes, he is. He doesn't know what it means. Senator Brashear doesn't know what it means. And it's not because they are ignorant people and it's not because Senator Maurstad is an ignorant man. It means that we're being given something which is not clear.

* * *

[p. 9413] SENATOR KIEL: Thank you, Madam Lieutenant Governor, members of the Legislature. I will just reiterate what I had said before and it goes to the impreciseness of the language in this bill. I think people have come to this debate very honestly and with a [p. 9414] lot of thought beforehand, but I think those people who are on this bill are ultimately going to be disappointed in the outcome because I do believe that, because of the vagueness and impreciseness of the language in the bill, that it will be found unconstitutional. Again, I wish that we could find some common ground in crafting language that would be more precise, that would be more direct, that people could actually sit down and say this is

the definition of this language, this is the definition of this word, but unfortunately we've not been able to do that. I will also say that I think probably this legislation will be found unconstitutional because it does not include any language with regard to protecting the health of the mother, and we haven't talked a whole lot about that at this stage of discussion. With that said, I will yield the rest of my time to Senator Chambers.

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[p. 9417] SENATOR CHAMBERS: Madam President, I have to ask Senator Maurstad a question . . .

PRESIDENT ROBAK: Senator Maurstad.

SENATOR CHAMBERS: . . . so that it will be clear from . . . for the record what I'm getting at. Senator Maurstad, you did mention this life-threatening situation. Now in whose opinion must it be deemed life-threatening?

SENATOR MAURSTAD: In the . . .

SENATOR CHAMBERS: That of the physician, or somebody . . .

SENATOR MAURSTAD: In the physician's.

SENATOR CHAMBERS: . . . who's going to review his conduct afterward?

SENATOR MAURSTAD: Clearly, with the amendment that was adopted on Select File, it is the physician who determines that.

SENATOR CHAMBERS: So all the . . . and this I want for the record. You're the sponsor of the bill. The

word of the physician is final when it comes to the determination of whether the woman was faced with a life-threatening situation. That is your intention.

SENATOR MAURSTAD: The physician need not be concerned relative to their judgment in this area, given the caveat, obviously, that they have to comply with the definition and with LB 23. But if they indicate that it's a life-threatening circumstance and if its challenge is upheld by the process, the appeal process, then they make the decision.

[p. 9418] SENATOR CHAMBERS: So then it is not really the physician's decision. He or she can be brought up on charges and have to prove to somebody else to their satisfaction that it was really life-threatening in their judgment rather than that of the physician. Isn't that true?

SENATOR MAURSTAD: But that's not unlike . . . that's not unlike other provisions in law that restrict the physician in one way or another.

SENATOR CHAMBERS: But doesn't that help you to better understand what I meant when I said that, even when a woman is facing a life-threatening situation, the physician may be unwilling to help because of the threat of the criminal prosecution? And it is there. But here's another question I want to ask you. When this, going to the part I'm trying to strike about this finding that the director is to make as a result of this proceeding, if the director finds that the physician in fact was faced with a situation that would allow this procedure without it being criminal, does that finding by the director mean

that the criminal charge should be dismissed? Will that end the issue . . .

SENATOR MAURSTAD: You're . . .

SENATOR CHAMBERS: . . . as far as the criminal charge?

SENATOR MAURSTAD: . . . you're indicating that the appeal process indicated that there was no violation of the . . . of this part of the statute and does . . .

SENATOR CHAMBERS: In the opinion of the director.

SENATOR MAURSTAD: Okay. And, so I have the question clear, then that would mean that there would be automatic dismissal of the criminal action? Was that your question?

SENATOR CHAMBERS: Yes.

SENATOR MAURSTAD: And the answer is, no, that that . . .

[p. 9419] SENATOR CHAMBERS: Right.

SENATOR MAURSTAD: . . . that that would have to be determined by the court. The findings of the director would be admissible in court and the, of course as I indicated last night, there would need to be a judgment made first by the prosecutor as to whether to proceed with the case given the findings of the director, but then, if so, then it would be the court that would make that final judgment on the criminal aspect.

SENATOR CHAMBERS: Thank you, Senator Maurstad. You've been very forthright, and it shows the

charade of this whole thing giving the impression, when we were discussing it superficially, and that's why I want to take it a step at a time, section by section, and get the sponsor to tell us what really is in the mind of those who support this bill. Having the hearing does not really have a bearing on criminal guilt or innocence. You're going to have . . .

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: . . . people trained in medicine to conduct a hearing, and if all of the evidence is presented and those who make the decision on a medical basis determine that there was a life-threatening situation facing this physician and they rule that the physician did not violate the law as written and given to them to make a judgment, it doesn't mean anything. The criminal prosecution goes on and, Senator Maurstad, isn't it true that the doctor could still be convicted, despite the finding of the director in favor of the doctor? The doctor could still be convicted in the criminal action, isn't that true? I'm, excuse me, Senator Maurstad's mike isn't on and we lost about 30 second.

SENATOR MAURSTAD: Senator, anything is of course possible. My evaluation would be, in that circumstance, not very probable.

SENATOR CHAMBERS: No, I'm asking you under this law . . .

SENATOR MAURSTAD: Yeah, well . . .

SENATOR CHAMBERS: . . . the doctor could still be convicted of a [p. 9420] crime, despite the finding in his favor . . .

SENATOR MAURSTAD: Yes, they're . . .

SENATOR CHAMBERS: . . . by the director.

SENATOR MAURSTAD: . . . two distinct and separate actions.

* * *

[p. 9435] SENATOR CHAMBERS: Madam President and members of the Legislature, I have to say that even my colleague, Senator Wesely, with whom I agree, has fallen into the trap of talking about a gruesome procedure. The definition does not talk about a gruesome procedure. What I have continued to try to hammer into the heads of my colleagues, and I've been totally unsuccessful, is that we have to look at the definition. And Senator Maurstad will have to help me with this. Senator Maurstad, and I wanted to save this question until we got on Senator Wesely's amendment, where in your definition anywhere, anyplace, does it say that any portion of the fetus is outside the mother?

PRESIDENT ROBAK: Senator Maurstad.

SENATOR MAURSTAD: I don't think the fetus can be outside the mother, Senator Chambers.

[p. 9436] SENATOR CHAMBERS: In this procedure.

SENATOR MAURSTAD: In this procedure, I don't think that . . .

SENATOR CHAMBERS: No portion of it is outside the mother.

SENATOR MAURSTAD: Well, okay, let . . . let me backtrack again. Could you ask the question again for me, so I . . . ?

SENATOR CHAMBERS: Yes. We have been talking and I've been luring everybody into the trap and they've fallen into it. I've been describing the procedure that you all say you're attempting to prohibit and that's where a portion of the fetus is outside the mother, except the head. And we've talked about that. Then I asked could a hand be outside, could a foot be outside? The answer was yes.

SENATOR MAURSTAD: Okay. I understand now.

SENATOR CHAMBERS: Okay. Now, according to your definition, no part of the fetus need be outside the mother. Isn't that true?

SENATOR MAURSTAD: We're talking about deliberately and intentionally delivering into the vagina . . .

SENATOR CHAMBERS: So . . .

SENATOR MAURSTAD: . . . so we're talking about a substantial portion thereof in the vagina.

SENATOR CHAMBERS: So no part of the fetus has to be outside the mother, does it, based on your definition?

SENATOR MAURSTAD: No.

SENATOR CHAMBERS: So this so-called gruesome procedure that Senator Wesely and Senator

Schimek, and I'm mentioning them because they support your bill but they're in favor of a woman's choice, have not looked at the definition for what it says. And, oh, and that's all I will ask you . . .

[p. 9437] SENATOR MAURSTAD: Okay.

SENATOR CHAMBERS: . . . at this point. What the definition does not say is that any portion of the fetus has to be delivered from the vagina, but only into the vagina. No part of the fetus is outside the woman. But when they came before the Judiciary Committee, when they talked about it before Congress that they . . . and they give pictures, they show the bulk of the fetus outside the mother feet first. That's what they're talking about. That's not what the definition is talking about. The definition is not talking about any of the things that have been discussed on this floor other than what I have discussed, and that's any abortion at any point during a pregnancy where the fetus passes through the vagina, and that's a crime if a physician participates in that type of abortion. If . . . let me ask Senator Maurstad a question.

PRESIDENT ROBAK: Senator Maurstad.

SENATOR MAURSTAD: Yeah.

SENATOR CHAMBERS: Senator Maurstad, if a fetus is delivered by way of Caesarian section, that would be an abortion too, wouldn't it?

SENATOR MAURSTAD: No.

SENATOR CHAMBERS: Or would it?

SENATOR MAURSTAD: No.

SENATOR CHAMBERS: It can only be an abortion if it's via the vagina? Is that true? I'm asking for information.

SENATOR MAURSTAD: The abortion, as I indicated in the definition, the important aspect of that is the killing of the unborn child.

SENATOR CHAMBERS: I thought it was the premature termination of the pregnancy by whatever means, based on the definition in the law, just an abortion, period.

[p. 9438] SENATOR MAURSTAD: Yeah.

SENATOR CHAMBERS: Here's what it says on . . .

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: . . . page 3, and it's from existing law: . . .

SENATOR MAURSTAD: Um-hum.

SENATOR CHAMBERS: . . . "Abortion means the use or prescription of any instrument, medicine, drug, or other substance or device intentionally to terminate the pregnancy of a woman . . .

SENATOR MAURSTAD: Right.

SENATOR CHAMBERS: . . . known to be pregnant".

SENATOR MAURSTAD: Right.

SENATOR CHAMBERS: So it could be by way of a Caesarian section and that's an abortion too, isn't it, . . .

SENATOR MAURSTAD: I . . . I . . .

SENATOR CHAMBERS: . . . based on the definition?

SENATOR MAURSTAD: As I indicated before, Senator, you know, whether it's possible and whether it's practical and whether it's done, you know, is irrelevant relative to this bill . . .

SENATOR CHAMBERS: But here's what I'm saying.

SENATOR MAURSTAD: The point is you could dismember a child and I suppose if you wanted to have a C-section to take out the dismembered parts. You could do that.

SENATOR CHAMBERS: Not dismember.

SENATOR MAURSTAD: I don't think that would be appropriate.

SENATOR CHAMBERS: If . . . if all you're intending to do is [p. 9439] terminate the pregnancy and if you do it by way of Caesarian section, that's an abortion by the definition in the law, isn't it?

SENATOR MAURSTAD: If it is . . .

PRESIDENT ROBAK: Time.

SENATOR MAURSTAD: . . . if it is done intentionally to terminate the pregnancy, it would be.

* * *

[p. 9445] SENATOR CHAMBERS: Is it your understanding that when abortions are performed, in

every instance the fetus is terminated within the womb? Is that your understanding?

SENATOR WITEK: Yes.

SENATOR CHAMBERS: So there's never been an instance where a fetus would emerge and not be dead in an abortion? A legal abortion?

SENATOR WITEK: That's why we came to this point in time because this is a procedure that is . . .

SENATOR CHAMBERS: No, that's . . . I am not talking . . .

SENATOR WITEK: . . . not . . .

[p. 9446] SENATOR CHAMBERS: No, I'm asking you about abortions, in general, because in the Judiciary Committee, when we have hearings, we hear many anecdotal examples that they give of what they call a botched abortion, and the fetus is still alive when it comes out of the woman and they terminate it outside the woman, but you're saying that doesn't happen. Is that what you're saying?

SENATOR WITEK: No, actually, I have heard where in some abortions that the child is not killed in utero, it is taken apart, suctioned out. I am not sure, I think at some point in time during that procedure, the child dies, but I think it's a very . . .

SENATOR CHAMBERS: But you are not aware of any instance where you called it a child, I call it a fetus, but, in any case, where it is still not dead. It is not dead when it emerges from the woman.

SENATOR WITEK: No, I am aware of instances where that has occurred. There have been people who have testified that they have delivered.

SENATOR CHAMBERS: Do you think there are any fetuses which are killed in the vagina during abortions?

SENATOR WITEK: I know that there is a saline solution that is used to supposedly kill the child, and is that what you're referring to?

SENATOR CHAMBERS: I'm just asking you, are you aware of any situations? Because I hear all these anecdotes. I don't know whether they are true or not, but that's all I'll ask you because I don't want to try to bring you into something where you're as unsure as I am of whether these things actually happened. But if, and I've heard even medical personnel talk about how they have worked in clinics and they have seen this happen, so maybe they are not telling the truth. But if these anecdotes are true, then it means when an abortion is performed, which is legal under the law, and the fetus is killed after it enters the vagina, that violates this statute here, at any point [p. 9447] in the pregnancy. This statute does not give a stage of the pregnancy where it comes into effect, so it applies throughout the term of the pregnancy, and no part of the fetus has to be outside the mother. All that's needed, based on this definition, is that the fetus or a substantial portion of it be in the vagina, not outside. So what you all have been talking about is not what this bill talks about, and I can't get that through you all's head. You're talking about something other than what is defined . . .

SPEAKER WITHEM: One minute.

SENATOR CHAMBERS: . . . in this bill, and this bill's definition includes far more that what you all are talking about, and if there is this miscarriage that is beginning, it could begin in an obstetrician's office. Somebody could be performing an examination and it could start, and there could be a complication. And if the doctor helped bring the fetus into the vagina, knowing that the result is that the fetus is going to die, that doctor, even though it's a miscarriage, is guilty, under this bill, of committing a crime based on the way you all define it. And you can shilly-shally and dance and dodge around it all you want to, it's fortunate that the courts and not these legislators who will stand up and say the bill is clear and sit down, and that means the bill is clear. Ridiculous and preposterous, read the language of the bill.

* * *

[p. 9459] SENATOR CHAMBERS: Senator Hilgert, without reading the whole definition, because you have heard that read over and over, what does "substantial portion" mean with reference to the fetus? What does "substantial portion" mean?

SENATOR HILGERT: You know I listened to that debate, and I understand that there was some problem quantifying that. I also looked in our statutes, criminal statutes, regarding . . . our obscenity statutes, actually, and they use words like "predominantly" and other suggestive terms, so I believe that . . . that it's probably a litigable term.

SENATOR CHAMBERS: Senator Hilgert, were they talking about an attitude, an idea, an opinion, or a physical item? We are talking about a physical item here.

SENATOR HILGERT: They were discussing physical items, because it had to do with actual pornographic material and . . .

SENATOR CHAMBERS: No, they . . . they were talking about the reason, the attitude. Weren't they talking about the attitude, Senator Hilgert? Be as straightforward as you said our discussion has been? What . . . when . . . okay, let me back up then. You read the statute. Tell me what the language was talking about in the statute that you read.

SENATOR HILGERT: I can't recall word for word. There's 16 hours of debate, and I believe you hammered on this point several times.

SENATOR CHAMBERS: But in the statutes where you found the term predominant, were they talking about the size of a drawing, the size of a tape, or what were they talking about?

SENATOR HILGERT: Okay, I understand where you are coming from [p. 9460] now. It probably is more of an attitude or characteristic, as such, the predominately puritan interest. I was looking for a definition of what you said is substantial, and although I've only found the word "substantial" used on Uniform Commercial Code, you, and as we discussed off the mike, you said, well, that's . . . that's not criminal, you know, Senator, you know that. So let's look for criminal and I did look for some.

SENATOR CHAMBERS: And we're talking about an object here.

SENATOR HILGERT: Yes.

SENATOR CHAMBERS: A quantifiable, measurable object. What would "substantial" be? Isn't it true that you cannot define it any better than the people who tried on the floor?

SENATOR HILGERT: I . . . yes, that is somewhat true. I think that everyone has an idea in their mind, that it's hard to quantify. That's why I said it's probably a litigable issue.

* * *

[p. 9462] SENATOR CHAMBERS: Everything flows from the definition, and if there are several people looking at it, and they have a different opinion as to what it means, that defines ambiguity and lack of clarity, wouldn't you agree?

SENATOR HILGERT: I would say that if several experts on the board, using your example, all came up with very disparate conclusions upon what the definitions referred to, based on LB 23, if it is to be passed into statute, I think that would, itself, define ambiguity.

* * *

[p. 9467] SENATOR CHAMBERS: Other things you would have done differently, if you were given this bill as it exists right now, and you're aware of the discussion we've had and the questions raised, would you draft the bill differently yourself, if you had total freedom to draft it in the way you thought fit?

SENATOR HILGERT: I would be more likely to draft a different bill, perhaps finding out what the courts will do when some of these questions are brought before them.

SENATOR CHAMBERS: So you wouldn't change the bill, if you were drafting it? You wouldn't change the definition. You would leave "substantial portion thereof"?

SENATOR HILGERT: Yes, frankly, I would because what you do is you end up saying, well, and I don't want to be grotesque or anything, but say, well, let's say we'll use percentages. If you had 30 percent of a fetus, using your terms, or a child, 30 percent, in the vagina, then you would . . .

SENATOR CHAMBERS: Would you have said that part of the fetus would have to be outside the woman, would you have said that?

SENATOR HILGERT: Probably not, I think that once the intent is to bring it . . .

SPEAKER WITHEM: Time, Senator Chambers. Senator Schimek.

SENATOR SCHIMEK: Yes, I yield my time to Senator Chambers.

SPEAKER WITHEM: Senator Chambers.

SENATOR CHAMBERS: Thank you, Senator Schimek. Senator Hilgert, when everybody talks about this procedure . . . you got your instructions again.

SENATOR HILGERT: No, I just wanted to make sure you had a chance . . .

SENATOR CHAMBERS: I'm toying with you.

SENATOR HILGERT: . . . to continue our conversation, Senator.

[p. 9468] SENATOR CHAMBERS: No, I am lightening the mood.This procedure that everybody has talked about has been depicted in drawings. It was discussed before the Judiciary Committee, and it was a very specific procedure they were talking about, and the majority of the fetus was outside the mother, or didn't you attend that hearing?

SENATOR HILGERT: Oh, I attended the hearing. You were . . .

SENATOR CHAMBERS: Isn't that why we have television sets?

SENATOR HILGERT: Yes.

SENATOR CHAMBERS: This is the technological age.

SENATOR HILGERT: No, you were at the enterprise zone hearing, I believe, during this hearing.

SENATOR CHAMBERS: But that hearing lasted a lot longer than the time I was at the enterprise zone hearing.

SENATOR HILGERT: Yeah, it did, but, yes, I did see those illustrations that I believe were taken out of some instructional manual . . .

SENATOR CHAMBERS: Right, they weren't talking . . .

SENATOR HILGERT: . . . to teach people how to do this.

SENATOR CHAMBERS: And they weren't talking about anything other than that which was depicted, when they came before the committee, isn't that true?

SENATOR HILGERT: Well, I think they were talking about it in the entirety. I think they were referring to that illustration a lot as the most . . . as the worst illustration, the most grotesque illustration as an example.

SENATOR CHAMBERS: But even when . . .

SENATOR HILGERT: That's why you use words like "substantial" [p. 9469] and so forth . . .

SENATOR CHAMBERS: No, but that would have had to say outside the woman's body.

SENATOR HILGERT: Right.

SENATOR CHAMBERS: This . . . your bill says just a portion of the fetus is in the vagina, not outside the body.

SENATOR HILGERT: We tried to be as encompassing as possible.

SENATOR CHAMBERS: Well, this bill doesn't deal with what was described and discussed in the committee though, does it?

SENATOR HILGERT: Well, I believe . . .

SENATOR CHAMBERS: It covers more than what they talked about in the committee, doesn't it?

SENATOR HILGERT: I would agree with that, Senator, yes, it does. This bill does encompass more than specific examples that people related and the illustrations presented by, and I forget the source where it came from.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 6

Mrs. Kiel asked unanimous consent to be excused until she returns. No objections. So ordered.

Mr. Maurstad withdrew his motion to suspend the rules.

BILL ON FINAL READING

The following bill was read and put upon final passage:

LEGISLATIVE BILL 23. With Emergency.

A BILL FOR AN ACT relating to abortions; to amend sections 28-325, 28-340, 71-148, 71-155, and 71-171.02, Reissue Revised Statutes of Nebraska, and section 28-326, Revised Statutes Supplement, 1996; to prohibit partial-birth abortions; to provide a penalty; to provide for professional license suspension and revocation; to harmonize provisions; to provide severability; to repeal the original sections; and to declare an emergency.

Whereupon the President stated: "All provisions of law relative to procedure having been complied with, the question is, 'Shall the bill pass with the emergency clause attached?' "

Voting in the affirmative, 45:

Abboud	Cudaback	Jensen
Beutler	Dierks	Jones
Bohlke	Elmer	Kristensen
Brashear	Engel	Landis

Bromm	Hartnett	Lynch
Brown	Hilgert	Matzke
Bruning	Hillman	Maurstad
Coordsen	Hudkins	McKenzie
Crosby	Janssen	Pedersen, Dw.
Pederson, D.	Stuhr	
Peterson, C.	Suttle	
Preister	Tyson	
Robak	Vrtiska	
Robinson	Wehrbein	
Schellpeper	Wesely	
Schimek	Wickersham	
Schmitt	Witek	
Schrock	Withem	

Voting in the negative, 1:

Chambers

Excused and not voting, 3:

Kiel Raikes Will

A constitutional two-thirds majority having voted in the affirmative, the bill was declared passed with the emergency clause and the title agreed to.

UNANIMOUS CONSENT – Members Excused

Messrs. Landis and Lynch asked unanimous consent to be excused until they

* * *

(32)

No. 99-830

Supreme Court, U.S.
FILED
FEB 2 8 2000
CLERK

In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

JOINT APPENDIX VOLUME III, PAGES 482 TO 731

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 7

AMERICAN MEDICAL ASSOCIATION'S "REPORT OF THE BOARD OF TRUSTEES ON LATE-TERM ABORTION"

* * *

PREVALENCE OF AND REASONS FOR INDUCED ABORTION

The Centers for Disease Control and Prevention (CDC) defines an induced abortion as "a procedure intended to terminate a suspected or known intrauterine pregnancy and to produce a nonviable fetus at any gestational age."[24*] A molar pregnancy, ectopic pregnancy, or fetal death diagnosed before any intervention are not regarded as an induced abortion.

The most scientifically reliable, national data on the incidence of abortion and characteristics of women who have abortions in the United States come from the Centers for Disease Control and Prevention and the Alan Guttmacher Institute (AGI). The Alan Guttmacher Institute is an independent, nonprofit corporation for research, policy analysis, and public education. Because the prevalence of late-term abortion procedures has been questioned in the popular press, it is worth describing the type of national abortion statistics which are collected in the United Statistics [sic] as well as methods of data collection.

---

* Endnotes beginning with 24 are reprinted at page 498.

Both the CDC and the AGI collect data on the total number of abortions in the United States. The CDC data are derived primarily from reports by state health departments, whereas the AGI collects data directly from abortion providers. For many years AGI estimates of the number of abortions performed in the United States each year have been higher and considered to be more accurate than those reported by the CDC.[25, 26] However, AGI does not collect data on gestational age. Instead, it uses CDC data on the number of abortions performed at various gestational ages and makes statistical adjustments for discrepancies between AGI and CDC data when publishing its estimates.

Although the CDC collects annual data on abortion, the data have limitations. First, all states do not provide abortion-related information to the CDC. As recently as 1992, Alaska, California, Iowa, New Hampshire and Oklahoma did not collect data on abortion. For these states the CDC conducted limited surveys of abortion providers or estimated the number of abortions.[25-27] Second, information from state health departments on abortion is often incomplete, with some states lacking information on as many as 40% to 50% of the abortions performed in the states.[26, 27] Third, the categories used by the CDC to report the method of abortion differentiate between D&E, labor induction procedures, and hysterotomy/hysterectomy, but they do not have a separate category for D&X. Fourth, states vary in their method of recording gestational age. Some use the number of weeks since the first day of the woman's last menstrual period, and others record the physician's estimate of gestational age. Finally, although the CDC is the only organization

which collects national data on abortion by weeks of gestation, it does not provide a detailed breakdown of abortions performed at 21 weeks and beyond.

Despite these limitations, the CDC and AGI remain the most reliable sources of national data on abortions. As shown in table 1, the vast majority (95%) of induced abortions are done at or before 15 weeks' gestation, in the first or very early second-trimester.[27]

Table 1: Induced Abortion: 1992

Gestational Age	Number	Percent of procedures
≤ 8 weeks	798,850	52%
9-10 weeks	377,570	25%
11-12 weeks	181,960	12%
13-15 weeks	94,060	6%
16-20 weeks	60,040	4%
21 weeks or more	16,450	1%
TOTAL	1,528,930	100%

A more detailed, estimated breakdown of the number of induced abortions at 21 weeks or more appears in Table 2.[27] The estimate is based on data from the CDC abortion surveillance reports, data collected by the National Center for Health Statistics (NCHS) from 14 states, and AGI survey data; estimates were calculated by the AGI. However, these estimates must be viewed cautiously. First, they are based on a limited number of states which may not be representative of the nation as a whole, and reporting by these states may be incomplete. Second, assuming that the number of providers who perform late-term abortions is relatively small,[27] they may have relatively large caseloads. The number of late-term abortions would

be underestimated if these providers were not in the NCHS sample. Third, random errors in coding gestational age could substantially inflate the estimated number of abortions performed beyond 26 weeks, because these procedures constitute such a small proportion of abortions overall. Fourth, clinician errors in estimating gestational age could bias the data in unknown ways. Finally, natural fetal deaths beyond 20 weeks of gestation reported to the NCHS may be mistakenly counted as abortions if the fetus were removed using procedures commonly used to induce abortion.[27]

Table 2: Estimated Number of Late-Second- and Third-Trimester Induced Abortions

Gestational Age	Number	Percent of procedures at 21 weeks or later
21-22 weeks	10,340	63%
23-24 weeks	4,940	30%
25-26 weeks	850	5%
>26 weeks	320	2%
TOTAL	16,450	100%

According to these estimates, two-thirds of abortions beyond 20 weeks are performed between 21 and 22 weeks. After 26 weeks, the number of abortions nationwide is estimated as being between 320 and 600. While it is not possible to quantify the type of D&E procedure used in these circumstances, it is estimated that 86% of all abortions performed past 20 weeks of gestation are performed by dilation and evacuation (D&E), and most of the remainder by inducing labor.[27]

In 1992, teenagers were more likely than older women to have an abortion at 16 weeks of gestation or later.[25] Approximately 9% of women 19 years of age and younger who had an abortion in 1992, had the procedure performed at 13 weeks of gestation or later, compared to 5% of women 20 years of age and older.[25] Seven percent of women who were black or of other races who had an abortion in 1992 had the procedure performed during the second- or third-trimester, compared to 5% of white women. Differences between Hispanic and non-Hispanic women were minimal (6.5% and 6.3%, respectively).[25]

Little research has been done on reasons for induced abortion in the second-trimester. In 1987, AGI conducted a survey of patients in 30 abortion facilities in which at least 400 abortions were performed annually and which performed abortions at 16 or more weeks of gestation.[28] The 30 providers represented each of the four regions of the country and the average patient response rate was 80 percent. Of the 1,900 women in the survey, 420 had been pregnant for 16 or more weeks and they were asked to report the most important reasons for their delay in having an abortion. Seventy-one percent reported that they did not recognize that they were pregnant or misjudged gestation. Forty-eight percent reported having difficulty making arrangements for an abortion (particularly raising enough money for the procedure), 33% were afraid to tell their parents or partner, and 24% reported having had great difficulty with the decision to have an abortion. Women having a later abortion were more likely than other women to cite personal health problems, possible fetal health problems, or rape or incest as having caused the pregnancy.

Medical reasons for second-trimester abortions can include maternal indications, such as those which threaten her health or life. For some women the condition may have existed prior to the pregnancy, for others a condition may have occurred during the pregnancy, and for others, the condition could have resulted from the pregnancy itself.

Some serious fetal abnormalities are not diagnosed until the second-trimester and the discovery of such anomalies prompt some women to decide to terminate the pregnancy by inducing abortion. Amniocentesis is usually performed between the 14th and 18th weeks of pregnancy, and the results usually are not available for another two to three weeks. Chorionic villus sampling (CVS) can be performed earlier, between the 10th and 12th weeks of pregnancy. Preliminary results are usually available within 48 hours and confirmatory, final results typically take a maximum of 7 to 10 days. However, the timing of an induced abortion prompted by the discovery of fetal anomalies through CVS or amniocentesis is almost certain to occur after the first trimester.

PROCEDURES USED TO INDUCE ABORTION

The procedure used to induce abortion depends, in part, on gestational age, commonly defined as the number of weeks since the first day of the last menstrual period, based on a 28-day menstrual cycle.[29] The percentage of reported legal abortions by weeks of gestation and type of procedure appears in Table 3.[25] As can be seen, suction or sharp curettage and dilatation and evacuation are the most common procedures used to induce abortion in the

United States (99%). However, by 16 weeks of gestation and beyond, approximately 9% of induced abortions are performed using labor induction techniques. Hysterotomy and hysterectomy are used very rarely, regardless of gestational age.

Table 3: Percentage of Reported Legal Abortions, by Weeks of Gestation and Type of Procedure – United States, 1992

	Weeks of gestation				
Type of procedure	<8-12 weeks	13-15 weeks	16-20 weeks	≥21 weeks	Total
Curettage (suction or sharp)[a]	99.9%	98.2%	86.0%	86.4%	99.0%
Labor induction[b]	0.0%[c]	1.0%	8.8%	9.1%	0.6%
Hysterotomy Hysterectomy	0.0%[c]	0.0%[c]	0.0%[c]	0.1%	0.0%[c]
Other[d]	0.09%	0.8%	5.1%	4.4%	0.4%
Total[e]	100%	100%	100%	100%	100%

[a]Includes dilatation and evacuation

[b]Includes intrauterine saline instillation and intrauterine prostaglandin instillation

[c]<0.05%

[d]Includes instillation procedures not reported as a specific category

[e]Reported by 35 states and New York City

First Trimester Procedures to Induce Abortion

Since the 1970s, vacuum aspiration, also referred to as suction curettage, has been the most common procedure used to induce abortion in the first trimester (i.e., from the 6th through 12th week of gestation).[25-26] Prior to the procedure a pelvic examination is done to determine the size and position of the uterus. A speculum is used to visualize the cervix, a local anesthetic such as a paracervical block is administered, and the cervix is then dilated using rigid dilators (e.g., the Pratt dilator.[30] Osmotic dilators may be used prior to the procedure. Once the cervix is sufficiently dilated, a suction tube is inserted and rotated inside the uterus to loosen and remove the contents. The suction tube may be attached to a suction machine or syringe. A curette may be used to scrape the endometrium, thereby ensuring the removal of any remaining tissue.[30,31] These procedures are typically performed on an outpatient basis.

Menstrual regulation, also known as menstrual extraction, is a type of early suction currettage. After inserting the cannula, the clinician attaches the syringe, releases the pinch valve, and suctions blood and tissue into the syringe. The procedure can be performed no later than 42 to 50 days from the last menstrual period.[32] Neither anesthesia nor dilation are usually necessary.

In the last several years, pharmaceutical agents have also been used to induce abortion in the first trimester. These include mifepristone (RU-486), a synthetic hormone, which can be used within 9 weeks of the last menstrual period.[31] Mifepristone causes the lining of the uterus to shed by blocking progesterone, thereby terminating the

pregnancy. To induce abortion, the woman takes one oral does of mifepristone followed a few days later by misoprostol, to stimulate uterine contractions and expel the embryo.[31] Methotrexate used in conjunction with misoprostol represents a second pharmaceutical approach.[33]

Early-Second-trimester Procedures to Induce Abortion

During the second-trimester the most common procedure used to induce abortion is dilation and evacuation (also referred to [sic] dilatation and evacuation or D&E), which refers generically to transcervical procedures performed at 13 weeks gestation or later.[34-36] Labor induction techniques can also be used during the second-trimester though they are more common in the late-second and third-trimesters. These procedures are described below.

Dilation and evacuation procedures are usually performed early in the second-trimester, that is, in the 13th through 15th week of gestation.[25, 36] Ultrasonography is used prior to the procedure to confirm gestational age, because the underestimation of gestational age can have serious consequences during a D&E procedure.[32, 37-39] D&E is similar to vacuum aspiration except that the cervix must be dilated more widely because surgical instruments are used to remove larger pieces of tissue. Osmotic dilators are usually used. Intraveous fluids and an analgesic or sedative may be administered. A local anesthetic such as a paracervical block may be administered, dilating agents, if used, are removed, and instruments are inserted through the cervix into the uterus to remove fetal and placental tissue. Because fetal tissue is friable and easily broken, the fetus may not be removed intact. The walls of the uterus are scraped with a curette to

ensure that no tissue remains. In pregnancies beyond 14 weeks, oxytocin is given intravenously to stimulate the uterus to contract and shrink.[30-32]

Mid-Second-Trimester and Third-Trimester Procedures to Induce Abortion

By the 16th to 24th week of gestation there are several alternative procedures that can be used to induce abortion, though some are more common than others. These include dilation and evacuation (which may or may not be preceded by induced fetal demise), dilation and extraction (D&X), labor induction, hysterotomy and hysterectomy.

By the 16th week of gestation, ultrasonography should be used to verify gestational age. Dilation and evacuation procedures performed in the mid- to late-second-trimester involve the preoperative use of laminaria or osmotic dilators (rather than surgical dilators) which are inserted in the endocervical canal in order to dilate the cervix. The procedure is usually performed under local anesthesia, using sedation and paracervical block. Intracervical vasopression is often used to minimize bleeding, and high dose oxytocin is administered intravenously prior to the procedure. Fetal tissue is extracted through the use of surgical instruments, followed by extraction of placental tissue and subsequent curettage.[32, 36] Because the fetus is larger at this stage of gestation (particularly the head), and because bones are more rigid, dismemberment or other destructive procedures are more likely to be required than at earlier gestational ages to remove fetal and placental tissue. Some physicians use intrafetal

potassium chloride or digoxin to induce fetal demise prior to a late D&E (after 20 weeks), to facilitate evacuation.[30]

To minimize uterine or cervical perforation either from instruments used during the D&E, or through piercing by fetal parts, some physicians use a form of D&E that has been referred to in the popular press as intact dilation and extraction (D&X). According to the American College of Obstetricians and Gynecologists, intact D&X is comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.[19] This procedure may minimize trauma to the woman's uterus, cervix, and other vital organs. Intact D&X may be preferred by some physicians, particularly when the fetus has been diagnosed with hydrocephaly or other anomalies incompatible with life outside the womb.

As gestational age increases, particularly during the 16th to 24th week, labor induction techniques are more commonly used to induce abortion.[25] Labor induction techniques can be subdivided by the type of abortifacient used (hypertonic solutions such as urea or saline), and prostaglandin inductions (e.g., prostaglandin E_2 suppositories).[32, 39] The use of hypertonic solutions typically produce fetal death from osmotic insult, and labor then usually follows. In a saline abortion, a needle is inserted through the abdomen and the amniotic sac is injected with a concentrated salt solution. This results in fetal

demise and induces contractions of the uterus. Over several hours, the contractions cause the cervix to dilate and the contents of the uterus to be expelled. Alternatively, urea, a nitrogen-based solution that causes fetal demise when injected into the amniotic sac, typically is used in conjunction with subsequent administration of prostaglandins, to induce contractions of the uterus and to expel its contents.[31] Unlike saline instillation, the use of urea does not cause maceration of the fetal tissues and thereby interfere with the histologic diagnosis of some types of fetal abnormalities.[40]

Hysterotomy and hysterectomy have been used to terminate pregnancy but are not used routinely as a form of abortion because maternal mortality and morbidity associated with these procedures are significantly greater than those associated with other procedures used to induce abortion.[26, 34, 41, 42] Hysterotomy involves the surgical delivery of the fetus through an incision in the uterine wall and the abdomen. Anesthesia is administered through an epidural, a spinal, or through general anesthesia. After removing the fetus the umbilical cord is cut and placenta removed. Hysterotomy involves major surgery and must be done in a hospital setting. It typically lengthens a woman's hospital stay and recovery.[31] Hysterectomy is appropriate in cases in which there is a preexisting pathology, such as large leiomyomas or carcinoma in situ of the cervix.[32]

ABORTION-RELATED COMPLICATIONS AND SEQUELAE

Maternal Mortality

Maternal mortality is the most serious complication resulting from induced abortion, and the risk of maternal death increases with gestational age. In 1991, the overall rate of maternal mortality was one per 167,000 abortions.[43] The risk of maternal death from induced abortion at 8 weeks gestation or less was one in 600,000 procedures, but by 16-20 weeks increased to one in 17,000 procedures. At 21 weeks or more it increased to one in 6,000 procedures, and exceeded the risk of maternal death from childbirth, which was one in 13,000 deliveries, though the difference was not statistically significant.[43]

Maternal mortality rates comparing dilation and evacuation, labor induction, and hysterectomy/hysterotomy at 13 weeks gestation or later are shown in Table 4.[44] For all types of procedures maternal mortality rates increase with gestational age, but they are significantly greater for hysterectomy and hysterotomy, regardless of gestational age. Maternal mortality rates, overall, are higher for labor induction than D&E (7.1 and 3.7, respectively), but mortality rates resulting from labor induction and D&E are comparable for induced abortions performed at 21 weeks or more (11.9 and 10.3).

Table 4: Maternal Mortality Rates* for Induced Abortion Procedures at 13 Weeks' Gestation or Later, United States, 1974-1987

	Weeks of gestation			
Type of procedure	13-15 weeks	16-20 weeks	≥21 weeks	Total
Dilation and evacuation	2.0	6.5	11.9	3.7
Labor induction	3.8	7.9	10.3	7.1
Hysterectomy/ hysterotomy	28.1	103.4	274.3	51.6

*Per 100,000 abortions

Maternal Morbidity

It is difficult to estimate abortion-related morbidity because definitions of what constitutes a complication vary widely, and because in the United States national data on abortion-related morbidity have not been collected on a systematic, ongoing basis. The best available national data on complications was collected during the 1970s by the Joint Program for the Study of Abortion (JPSA), sponsored by the Population Council (New York, NY) and the CDC.[45] JPSA consisted of three prospective studies of abortion between 1971 and 1978, and involved a sample of hospitals and clinics throughout the United States. Between 73,000 and 84,000 women were involved in each phase of the research program.

The most commonly used indicator of abortion-related morbidity is admission to a hospital. This excludes minor physical sequelae but captures fairly accurately the more

serious maternal aftereffects of induced abortion. The CDC defines major complications from induced abortion as those that result in major unintended surgery, a hemorrhage requiring a blood transfusion, a hospitalization of 11 days or more, or a temperature of at least 38.0°C (100.4°F) that lasts for 3 or more days.[46]

Between 1970 and 1990 the overall risk of major complications from abortion-related procedures declined dramatically. From 1970 to 1971 there were eight major complications per 1000 abortion patients who did not have a preexisting medical condition or undergo sterilization in those years.[47] Between 1975 and 1978 the rate dropped to five major complications per 1000 abortions,[46] and by 1990, the National Abortion Federation (Washington, DC) estimated that there was one complication per 1000 abortions.[48] The overall decline in complication rates can probably be attributed to an increased proportion of procedures being performed earlier in the pregnancy, improvements in medical technology, and improvements in medical training.

The risk of complications is related to the abortion method used. Between 1975 and 1978, the last years of the Joint Program for the Study of Abortion, the complication rate associated with vacuum aspiration was two per 1000 procedures, while dilation and evacuation had a complication rate of seven per 1000 procedures. Procedures that induced labor (saline or prostaglandin instillation) had a higher rate (21 and 25 per 1000 procedures, respectively), and those involving major surgery had the highest rate of complications.[47]

The risk of complications and complication rates from induced abortion are also related to gestational age. From 1975 to 1978 there were between 1 and 4 major complications per 1000 procedures performed through the 12th week of gestation.[32] There were 6 major complications per 1000 procedures performed in weeks 13 to 14, 13 per 1000 in weeks 15 to 16, and 19 per 1000 in weeks 17 through 20.[32]

More recent, international data have also shown that complication rates increase with gestational age. Direct comparisons on abortion-related complication rates between countries must be made with caution because of differences in the definition and measurement of complications. Nonetheless data from 1988 for Denmark, West Germany, and New York state, and from 1987 for Canada, England and Wales, showed complication rates ranging from 0.4% to 3.4% for first-trimester abortions, and from 1.1% to 8.7% for second-trimester abortions.[49] However, more research on major complication rates associated with various procedures and by gestational age is needed before any firm conclusions about the relative safety of procedures can be made.

Cervical incompetence and compromised subsequent pregnancies are important but unresolved concerns related to abortions performed in the second- or third-trimester. Unfortunately, there is little research on whether these complications are more likely to result from D&E (or intact D&X), or from labor induction techniques. Some physicians prefer D&E over labor induction methods for second-trimeser abortions because, they argue, it has a lower mortality rate, it takes less time, it is less expensive, it can be done on an outpatient basis, and

it takes less of a psychological toll on some women because it does not imitate labor.[33, 50, 51] Other physicians prefer to induce labor because they find it a less distastefull procedure.[50] Still others prefer it because they feel that it is less likely to interfere with the diagnosis of cytogenetic, anatomical, or DNA abnormalities in the fetus, particularly if saline instillation is avoided.[52] However, one research study involving 60 patients who underwent D&E at 14-22 weeks of gestation after fetal abnormalities were detected, found that D&E successfully and consistently confirmed abnormal prenatal diagnoses.[40]

In summary, maternal mortality during second-trimester abortions is lower for dilation and evacuation procedures than for labor induction methods. However, for procedures performed at 20 weeks' gestation and beyond, the rates are similar. More systematic research is needed on complications and complication rates associated with various types of abortion procedures at 13 weeks of gestation and beyond.

* * *

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 9

NEBRASKA
1996
Statistical Report
of
Abortions

Nebraska Health & Human Services System
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NEBRASKA ABORTIONS, 1996

This report presents tabulations of statistical information reported on records of induced abortions performed in Nebraska during 1996. These data are in compliance with specifications set forth in Nebraska Statute 28-325 - 28-347.

A total of 5,214 abortions were reported to the Nebraska Department of Health and Human Services during 1996, an increase of 7.8% when compared to the 1995 total of 4,838. The following chart shows the number of abortions performed; the percentage of abortions in different age groups; the mean and modal age of the patient; and the number of abortions per 1,000 live births since 1976.

Chart I:

Year	Total	19 and Under Percent	20-29 Percent	30 and Over Percent	Mean Age	Modal Age	Ratio*
1977	4,534	41.8	47.1	11.1	22.0	19	177.4
1978	4,838	42.1	46.5	11.4	22.0	19	190.3
1979	4,936	39.7	48.3	12.1	22.3	18	185.8
1980	6,060	34.8	52.4	12.8	22.7	19	219.0
1981	5,753	33.0	53.7	13.3	22.9	18	209.1
1982	5,698	31.8	55.0	13.2	23.0	19	209.2
1983	5,625	30.8	55.8	13.4	23.0	19	211.5
1984	5,995	30.1	55.2	14.6	23.2	20	226.7
1985	6,012	30.0	55.3	14.7	23.3	20	232.3
1986	5,761	30.2	53.5	16.3	23.4	19	232.7
1987	5,858	30.0	53.2	16.8	23.5	18	243.2
1988	6,006	29.3	52.8	17.9	23.8	19	247.5
1989	5,871	29.0	51.4	19.6	24.1	19	239.5
1990	6,346	28.6	52.1	19.4	23.9	19	257.7
1991	6,194	24.6	55.2	20.2	24.3	21	256.0
1992	5,637	22.7	56.6	20.7	24.5	21	238.4
1993	5,486	22.4	55.6	22.0	24.6	20	234.6
1994	5,324	22.1	55.0	22.8	24.7	22	229.2
1995	4,838	22.2	55.0	22.9	24.8	23	205.4
1996	5,214	22.3	54.5	23.2	24.9	19,22	222.0

*Abortions per 1,000 live births. The 1996 ratio is provisional.

Table 1: Number of Abortions by Month
Nebraska, 1996

Number by Month	
January	604
February	399
March	501
April	442
May	496
June	380
July	392
August	483
September	362
October	434
November	432
December	289
TOTAL	5,214
Average per Month:	435

Table 2: Number of Abortions by State of Residence
Nebraska, 1996

State of Residence	
Arizona	2
California	1
Colorado	3
Florida	2
Hawaii	1
Idaho	1
Illinois	2
Indiana	2
Iowa	766
Kansas	17
Kentucky	1
Michigan	1
Minnesota	7
Missouri	28

Nebraska	4,169
New Jersey	1
New York	1
North Carolina	1
North Dakota	1
Oklahoma	1
South Carolina	1
South Dakota	183
Tennessee	1
Texas	3
Wyoming	2
Canada	1
Unknown	15

Table 3: Number and Percent of Abortions by Age of Patient Nebraska, 1996

Age of Patient	Number	Percent
<15	25	0.5
15-19	1,138	21.8
20-24	1,749	33.5
25-29	1,087	20.8
30-34	659	12.6
35-39	424	8.1
40-44	115	2.2
>44	7	0.1
Unknown	10	0.2
TOTAL	5,214	100.0

Mean Age: 24.9 Median Age: 24.1 Modal Age: 19, 22

Please note: For the table Number and Percent of Abortions by Age of Patient, the percentage does not add to 100.0 because of rounding.

Table 4: Number and Percent of Total Abortions by Reason Nebraska, 1996

Reason for Abortion	Number	Percent of Total Abortions
Socio-Economic	2,879	55.2
Physical Health	38	0.7
Imminent Peril	2	0.0
Mental Health	644	12.4
Rape	3	0.1
Other	2,319	44.5
Unknown	816	15.7
TOTAL	6,701*	

* – These figures do not equal the total number of abortions due to the indication of multiple reasons on some reports.

Table 5: Number and Percent of Total Abortions by Method Nebraska, 1996

Method	Number	Percent of Total Abortions
Suction Curettage	5,161	99.0
Sharp Curettage	550	10.5
Other	49	0.9
Unknown	4	0.1
TOTAL	5,764*	

* – These figures do not equal the total number of abortions due to the indication of multiple methods on some reports.

Table 6: Number and Percent of Previous Abortions Nebraska, 1996

Previous Abortions	Number	Percent
0	3,139	60.2
1	1,282	24.6
2	445	8.5
3	165	3.2
4	79	1.5
>4	94	1.8
Unknown	10	0.2
TOTAL	5,214	100.0

Table 7: Number of Abortions by Number of Physicians Nebraska, 1996

Number of Abortions	Number of Physicians	Abortions Performed
<25	3	9
25-499	0	0
>499	5	5,205
TOTAL	8	5,214

Table 8: Previous Parity* by Age of Patient
Nebraska, 1996

		Number of Live Births							
Age	Total	0	1	2	3	4	5	6	≥6
TOTAL	5,214	2,520	1,222	865	392	140	49	18	8
12	1	1							
13	3	3							
14	21	21							
15	66	65	1						
16	159	150	9						
17	187	176	11						
18	350	300	47	3					
19	376	290	73	12	1				
20	354	226	97	24	5	2			
21	371	220	115	27	7	2			
22	376	214	114	34	10	4			
23	317	155	93	45	23		1		
24	331	137	98	70	20	4	1	1	
25	285	98	92	71	14	6	4		
26	236	99	66	42	21	7	1		
27	224	70	58	54	31	10	1		
28	172	40	49	48	24	9	2		
29	170	43	54	32	28	11	2		
30	161	35	38	49	23	8	3	4	1
31	132	35	27	42	21	3	2	1	1
32	140	28	30	50	17	9	1	3	2
33	117	21	27	38	17	7	3	3	1
34	109	16	23	39	16	11	4		
35	108	18	28	32	21	6	2		1
36	109	19	19	39	19	7	4	1	1
37	73	12	12	21	16	7	5		
38	67	6	9	25	16	8	1	2	
39	67	8	9	24	15	7	3	1	
40	49	5	9	19	10	4	1		1
41	32		3	13	9	2	3	2	
42	14		3	5	2	2	2		
43	10	2	2	3	2		1		
44	10	1	2	1	3	2	1		
45	1						1		
46	5	1	1	2	1				
49	1					1			
Unknown	10	5	3	1		1			

* - Number of live births previous to this abortion.

Table 9: Gravidity* by Age of Patient
Nebraska, 1996

Age	Total	Number of Pregnancies								
		1	2	3	4	5	6	7	8	≥8
TOTAL	5,214	1,685	1,142	882	603	395	198	129	70	110
12	1	1								
13	3	3								
14	21	21								
15	66	59	7							
16	159	131	26	2						
17	187	148	30	8	1					
18	350	229	98	17	5	1				
19	376	214	102	44	10	5	1			
20	354	154	109	54	23	7	3	4		
21	371	145	109	71	32	11	1	1		1
22	376	136	114	76	27	15	4	3		1
23	317	89	87	64	44	10	11	5	6	1
24	331	80	82	65	54	23	9	6	7	5
25	285	53	70	77	36	21	13	5	3	7
26	236	53	51	45	40	25	7	5	4	6
27	224	37	45	41	41	24	21	7	2	6
28	172	22	36	34	28	30	11	3	4	4
29	170	18	32	35	22	29	16	13	1	4
30	161	20	23	27	27	29	10	10	7	8
31	132	16	16	28	27	22	10	2	4	7
32	140	11	20	26	26	23	7	9	6	12
33	117	10	13	23	23	15	11	7	6	9
34	109	5	9	29	19	16	12	8	6	5
35	108	5	15	32	18	16	7	5	3	7
36	109	9	12	20	18	15	11	13	4	7
37	73	5	11	14	15	10	4	6	2	6
38	67	2	6	9	25	12	6	5	1	1
39	67	2	4	14	15	15	3	5	2	7
40	49	1	6	10	11	10	7	1	1	2
41	32		1	6	9	3	7	3	1	2
42	14		1	4	2	2	4	1		
43	10	1	2	3	2	1		1		
44	10	1		3		2	2	1		1
45	1									1
46	5		2	1	1	1				
49	1					1				
Unknown	10	4	3		2	1				

* - Total pregnancies, including this abortion and all previous live births, still births, and abortions.

Table 5: Number and Percent of Total Abortions by Method Nebraska, 1995

Method	Number	Percent of Total Abortions
Suction Curettage	4,831	99.9
Sharp Curettage	380	7.9
Other	5	0.1
Unknown	2	0.0
TOTAL	5,218*	

* * *

Table 7: Number of Abortions by Number of Physicians Nebraska, 1995

Number of Abortions	Number of Physicians	Abortions Performed
<25	6	25
25-499	2	450
>499	3	4,363
TOTAL	11	4,838

* – These figures do not equal the total number of abortions due to the indication of multiple methods on some reports.

* * *

Table 5: Number and Percent of Total Abortions by Method Nebraska, 1994

Method	Number	Percent of Total Abortions
Suction Curettage	5,306	99.7
Sharp Curettage	304	5.7
Other	8	0.2
Unknown	11	0.2
TOTAL	5,629*	

* * *

Table 7: Number of Abortions by Number of Physicians Nebraska, 1994

Number of Abortions	Number of Physicians	Abortions Performed
<25	8	30
25-499	1	490
>499	3	4,796
Unknown		8
TOTAL	12	5,324

* – These figures do not equal the total number of abortions due to the indication of multiple methods on some reports.

* * *

Table 5: Number and Percent of Total Abortions by Method Nebraska, 1993

Method	Number	Percent of Total Abortions
Suction Curettage	5,480	99.9
Sharp Curettage	2	0.0
Other	3	0.1
Unknown	2	0.0
TOTAL	5,487*	

* * *

Table 7: Number of Abortions by Number of Physicians Nebraska, 1993

Number of Abortions	Number of Physicians	Abortions Performed
<25	5	21
25-499	2	425
>499	3	5,031
Unknown		9
TOTAL	10	5,486

* – These figures do not equal the total number of abortions due to the indication of multiple methods on some reports.

* * *

Table 5: Number and Percent of Total Abortions by Method Nebraska, 1992

Method	Number	Percent of Total Abortions
Suction Curettage	5,625	99.8
Sharp Curettage	5	0.1
Intra-uterine prostaglandin instillation	3	0.1
Hysterotomy	0	–
Hysterectomy	1	0.0
Other	3	0.1
Unknown	6	0.1
TOTAL	5,643*	

* * *

Table 7: Number of Abortions by Number of Physicians Nebraska, 1992

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	10	60
25-499	1	36
>499	4	5,482
Unknown		59
TOTAL	15	5,637

* – These figures do not equal the total number of abortions due to the indication of multiple methods on some reports.

* * *

Table 5: Number and Percent of Total Abortions by Method Nebraska, 1991

Method	Number	Percent of Total Abortions
Suction Curettage	6,147	99.2
Sharp Curettage	2	0.0
Hysterotomy	0	–
Hysterectomy	0	–
Other	37	0.6
Unknown	9	0.1
TOTAL	6,195*	

* – These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

Table 7: Number of Abortions by Number of Physicians Nebraska, 1991

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	12	56
25-499	0	0
>499	3	6,138
TOTAL	15	6,194

* * *

NEBRASKA ABORTIONS

1990

* * *

Method	Number	Percent
Suction Curettage	6,254	98.5
Sharp Curettage	2	0.0
Hysterotomy	1	0.0
Hysterectomy	22	0.3
Other	13	0.2
Unknown	56	0.9
TOTAL	6,348**	100.0*

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	14	58
25-499	0	0
>499	3	6,288
TOTAL	17	6,346

* – Does not equal 100.0 due to rounding.

** – These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1989

* * *

Method	Number	Percent
Suction Curettage	5,862	99.7
Sharp Curettage	6	0.1
Other	1	0.0
Unknown	8	0.1
TOTAL	5,877**	100.0*

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	13	50
25-499	0	0
>499	3	5,821
TOTAL	16	5,871

* – Does not equal 100.0 due to rounding.

** – These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1988

* * *

Method	Number	Percent
Suction Curettage	5,992	99.7
Sharp Curettage	6	0.1
Other	4	0.1
Unknown	11	0.2
TOTAL	6,013*	100.0**

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	9	29
25-49	0	0
50-99	0	0
100-499	2	635
>499	3	5,342
TOTAL	14	6,006

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

**Does not equal 100.0 due to rounding.

* * *

NEBRASKA ABORTIONS

1987

* * *

Method	Number	Percent
Suction Curettage	5,849	99.8
Sharp Curettage	2	0.0
Other	4	0.1
Unknown	6	0.1
TOTAL	5,861*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	10	42
25-49	0	0
50-99	0	0
100-499	1	214
>499	3	5,602
TOTAL	14	5,858

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1986

* * *

Method	Number	Percent
Suction Curettage	5,757	99.9
Sharp Curettage	2	0.0
Hysterotomy	1	0.0
Unknown	3	0.1
TOTAL	5,763*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	10	34
25-49	0	0
50-99	0	0
100-499	1	199
>499	4	5,528
TOTAL	15	5,761

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1985

* * *

Method	Number	Percent
Suction Curettage	6,009	99.8
Sharp Curettage	9	0.1
Unknown	2	0.0
TOTAL	6,020*	99.9**

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	11	46
25-49	0	0
50-99	0	0
100-499	2	386
500 +	3	5,580
TOTAL	16	6,012

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

**Does not equal 100.0 due to rounding.

* * *

NEBRASKA ABORTIONS

1984

* * *

Method	Number	Percent
Suction Curettage	5,992	99.7%
Sharp Curettage	12	0.2
Hysterectomy	1	0.0
Unknown	1	0.0
TOTAL	6,009*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
<25	15	69
25-49	0	0
50-99	1	64
100-499	1	215
500 +	3	5,647
TOTAL	20	5,995

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1983

* * *

Method	Number	Per Cent
Suction Curettage	5,592	99.1%
Sharp Curettage	21	0.4
Intra-Uterine Saline Instillation	1	0.0
Intra-Uterine Prostaglandin Instillation	1	0.0
Hysterotomy	2	0.0
Other	23	0.4
Unknown	3	0.1
TOTAL	5,643*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
< 25	21	93
25-49	0	0
50-99	0	0
100-499	1	200
500 +	3	5,332
TOTAL	25	5,625

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1982

* * *

Method	Number	Per Cent
Suction Curettage	5,689	99.6%
Sharp Curettage	18	0.3
Intra-Uterine Prostaglandin Instillation	1	0.0
Hysterectomy	1	0.0
Unknown	4	0.1
TOTAL	5,713*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
< 25	14	75
25-49	1	25
50-99	0	0
100-499	1	219
500 +	3	5,379
TOTAL	19	5,698

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1981

* * *

Method	Number	Per Cent
Suction Curettage	5,742	99.2%
Sharp Curettage	39	0.7
Intra-Uterine Prostaglandin Instillation	1	0.0
Hysterectomy	2	0.0
Other	3	0.0
Unknown	2	0.0
TOTAL	5,789*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
< 25	21	85
25-49	0	0
50-99	0	0
100-499	1	137
500 +	3	5,531
TOTAL	25	5,753

*These figures do not equal the total number of abortions due to the indication of multiple reasons or methods on some reports.

* * *

NEBRASKA ABORTIONS

1980

* * *

Method	Number	Per Cent
Suction Curettage	6,050	99.1%
Sharp Curettage	52	0.9
Intra-Uterine Saline Instillation	1	0.0
Intra-Uterine Prostaglandin Instillation	1	0.0
Hysterectomy	2	0.0
Unknown	2	0.0
TOTAL	6,108*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
≤24	19	113
25-49	1	29
50-99	0	0
100-499	1	111
≥500	3	5,807
TOTAL	24	6,060

*These figures do not equal the total number of abortions because some reports indicate more than one reason or method.

* * *

ABORTIONS

1979

* * *

Method	Number	Per Cent
Suction Curettage	4,836	95.7
Sharp Curettage	123	2.4
Intra-Uterine Saline Instillation	84	1.7
Hysterotomy	2	0.0
Other	6	0.1
Unknown	2	0.0
TOTAL	5,053*	100.0

* * *

Physicians Performing Abortions

Number of Abortions	Number of Physicians	Total Number of Abortions Performed
≤24	24	116
25-49	0	0
50-99	0	0
100-499	0	0
≥500	3	4,820
TOTAL	27	4,936

*These figures do not equal the total number of abortions because some reports indicate more than one reason or method.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 11

[SEAL]

STATE OF NEBRASKA

United States of America,)
) ss.
State of Nebraska)

Department of State

I, Scott Moore, Secretary of State of the State of Nebraska do hereby certify that

TITLE 174 – Nebraska Administrative Code – Chapter 8 – Form 1 – Records Management Service Report of Induced Abortion; and Form 2 – Certificate of Fetal Death – as adopted by the Nebraska State Health Department – Bureau of Vital Statistics were last partially amended and filed in the Office of the Secretary of State on December 17, 1996.

I further certify that there have been no amendments nor changes to the above mentioned Rules and Regulations since the above amendment date and have been in full force and effect through and including the current date of certification.

Finally I hereby certify that said Rules and Regulations were approved in the offices of the ATTORNEY GENERAL and the GOVERNOR of the State of Nebraska.

In Testimony whereof,

[SEAL]

I have hereunto set my hand and affixed the Great Seal of the State of Nebraska.

Done at Lincoln this Tenth day of July in the year of our Lord, one thousand nine hundred and Ninety Seven

/s/ Scott Moore
SECRETARY OF STATE

STATE OF NEBRASKA DEPARTMENT OF HEALTH

Records Management Service
Report of Induced Abortion

FILED
DEC 17 1996

(Please print or type)

(State file number)

1. Name of Facility

Facility Address

Date of Abortion performed
Month Year

2. Facility chart case no.

4. Patient's legal residence
(State) (County - Optional)

5. Age last birthday

6. Marital status: ☐ Never married ☐ Widowed ☐ Separated ☐ Now married ☐ Divorced ☐ Unknown

7. Race: American Indian, Black, White, Asian/Pacific Islander, Other (specify) _____

Ancestry: Specify _____
Examples: French, Filipino, a Native American Tribe, English, Hispanic (such as Cuban, Mexican, or Puerto Rican), German, etc.

8. Education (check the highest grade or level completed)

None: 0 ☐
elementary or secondary: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐
college: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ ☐

9. Previous pregnancies, abortions, and live births. (Complete all four sections; enter number or check none)

Live Births		Other Terminations
a. Now living Number _____ None ☐	b. Now dead Number _____ None ☐	c. Spontaneous abortions, miscarriages, stillbirths, and fetal deaths Number _____ None ☐

10. Clinical estimate of gestation
_____ (weeks)

11. Length of fetus _____ inches
not measurable ☐

12. Check the stated reason(s) for abortion:

- ☐ Maternal physical health
- ☐ Mental health
- ☐ Maternal life endangered
- ☐ Fetal abnormality
- ☐ Socio-economic
- ☐ Sexual assault
- ☐ [illegible]
- ☐ Contraceptive failure
- ☐ [illegible]

14. Type of procedure performed
Check one

1. ☐ Suction curettage
2. ☐ Medical induced
3. ☐ Dilation and evacuation
4. ☐ Sharp curettage
5. ☐ Dilation and [illegible]
6. ☐ Other

16. Did [illegible]
Yes ☐

17. Name of attending physician (type/print)

18. Initial of person completing report and phone number: (type/print)

19. Attending physician's signature

APPROVED
1-017-96

APPROVED
JOHN P. LEE
ATTORNEY GENERAL
NOV 27 1996

To be reported within fifteen (15) days of the end of the calendar month in which the abortion was performed.

Mail to: Records Management Service
P.O. Box 95065
Lincoln, NE 68509-5065

**Shaded areas are required by law.
See back for explanation.

RV Lynn A. Nelson -revised 10/08/96-

530

BEST AVAILABLE COPY

BUREAU OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

FETUS

PARENTS

CAUSE

CERTIFIER

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

APPROVED
STENBERG
EY GENERAL
C 3 1991

APPROVED
JAN 13 1992

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 12

Bureau of Vital Statistics

REPORT OF INDUCED TERMINATION OF PREGNANCY

FACILITY—LOCATION (Street Address)	CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION	COUNTY OF PREGNANCY TERMINATION
1a.	1b.	1c.

AGE OF PATIENT	RESIDENCE-STATE	PREVIOUS PREGNANCIES (Complete each section)			
		LIVE BIRTHS		OTHER TERMINATIONS	
		How living Number ____ None ☐	How dead Number ____ None ☐	Spontaneous Number ____ None ☐	Induced Number ____ None ☐
2.	3.	4a.	4b.	4c.	4d.

LENGTH OF FETUS	WEIGHT OF FETUS
5. _____ (not measurable) ☐	6. _____ (not measurable) ☐

7. REASON(S) ABORTION REQUESTED

☐ Socio-Economic ☐ Imminent Peril to Woman's Life or Health
☐ Physical Health ☐ Mental Health
☐ Other (Specify) _____

8a. PROCEDURE THAT TERMINATED PREGNANCY (Check only one)	TYPE OF TERMINATION PROCEDURES	8b. ADDITIONAL PROCEDURE USED FOR THIS TERMINATION, IF ANY (Check all that apply)
☐	SUCTION CURRETTAGE	☐
☐	SHARP CURRETAGE	☐
☐	INTRA-UTERINE SALINE INSTILLATION	☐
☐	INTRA—UTERINE PROSTAGLANDIN INSTILLATION	☐
☐	HYSTEROTOMY	☐
☐	HYSTERECTOMY	☐
☐	OTHER (Specify) _____	☐

9. COMPLICATIONS OF PREGNANCY TERMINATION

(Check all that apply)
☐ NONE
☐ HEMORRHAGE
☐ INFECTION
☐ UTERINE PERFORATION
☐ CERVICAL LACERATION
☐ RETAINED PRODUCTS
☐ OTHER (Specify) _____

10. DID AN EMERGENCY SITUATION CAUSE THE PHYSICIAN TO WAIVE ANY OF THE REQUIREMENTS OF SECTION 28-327
Yes ☐ No ☐

11a. Attending Physician _____
(Signature)

11b. Attending Physician _____
(Print or type name and address)

Mail to: Bureau of Vital Statistics
301 Centennial Mall South
P. O. Box 95007
Lincoln, Nebraska 68509—5007

To be mailed within fifteen days after each reporting month.

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEBRASKA
[Caption Omitted In Printing]

EXHIBIT 17

TABLE 16. Reported legal abortions, by weeks of gestation and type of procedure* – United States, 1992

	Weeks of gestation													
	≤8		9-10		11-12		13-15		16-20		≥21		Total	
Type of procedure	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Curettage (suction or sharp)†	362,453	99.9	166,815	99.9	82,911	99.6	40,740	98.2	25,180	86.0	8,505	86.4	686,604	99.0
Intrauterine saline instillation	43	0.0§	32	0.0§	53	0.1	200	0.5	1,324	4.5	422	4.3	2,074	0.3
Intrauterine prostaglandin instillation	22	0.0§	19	0.0§	36	0.0§	199	0.5	1,273	4.3	469	4.8	2,018	0.3
Hysterotomy/ Hysterectomy	11	0.0§	7	0.0§	3	0.0§	3	0.0§	11	0.0§	6	0.1	41	0.0§
Other¶	282	0.1	70	0.0§	211	0.3	325	0.8	1,495	5.1	437	4.4	2,820	0.4
Total**	362,811	100.0	166,943	100.0	83,214	100.0	41,467	100.0	29,283	100.0	9,839	100.0	693,557	100.0

* Excludes unknowns.
† Includes dilatation and evacuation.
§ ≤0.05%.
¶ Includes instillation procedures not reported as a specific category.
** Reported by 35 states and New York City.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 20

STATE OF NEBRASKA
[SEAL] **Office of the Attorney General**
2115 STATE CAPITOL BUILDING
LINCOLN, NEBRASKA 68509-8920
(402) 471-2682
TDD (402) 471-2682
CAPITOL FAX (402) 471-3297
1235 K ST. FAX (402) 471-4725

DON STENBERG
ATTORNEY GENERAL

STEVE GRASZ
LAURIE SMITH CAMP
DEPUTY ATTORNEYS GENERAL

November 22, 1995

Leroy H. Carhart, M.D.
Abortion and Contraception
Clinic of Nebraska
1002 W. Mission Avenue
Bellevue, NE 68005

RE: Advertisement for Potentially Illegal Abortions

Dear Dr. Carhart:

It has come to our attention that your "yellow page" advertisements from the current Omaha and Lincoln telephone directories both advertise that your clinic performs "pregnancy termination through the 24th week."

In *Roe v. Wade* the United States Supreme Court recognized that states have a compelling interest in the life of a viable fetus. In fact, after viability the State's interests in preserving the life of the child are so strong that the

State may outlaw abortion so long as the law provides an exception to preserve the life and health of the mother. *See Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2804 (1992). The State of Nebraska has, in fact, made it a felony to perform an abortion after viability. Neb. Rev. Stat. § 28-329 (1989).

Viability may not be determined according to some arbitrary schedule (i.e. 24 weeks), especially in light of ever-improving medical technology. In Nebraska, viability is defined as that stage of human development when the unborn child is potentially able to live more than merely momentarily outside the womb of the mother by natural or artificial means. Neb. Rev. Stat. § 28-326.

The U.S. Supreme Court has upheld mandatory viability testing at *20 weeks. Webster v. Reproductive Health Services*, 109 S. Ct. 3040, 3057 (1989) (note: this was six years ago). According to the Nebraska Department of Health, at 24 weeks (the age advertised by your clinic) the chance of survival outside the womb is 80 percent! (The state of Pennsylvania reports the survival rate is 82 percent). Again, abortions are *illegal* in Nebraska after the time at which the child can live even "more than momentarily" by natural or artificial means unless necessary to save the life or health of the mother.

In light of your public advertisement of "pregnancy termination through the 24th week", you are requested to respond to the following questions:

1). Does your clinic perform abortions after the stage of human development when the unborn child is potentially able to live more than merely momentarily outside the womb of the mother by natural or artificial means?

2). If so, are these abortions limited to instances where it is necessary to preserve the life or health of the mother?

3). Do you consider all abortions necessary to preserve the health of a woman who desires an abortion? If not, which abortions are not necessary to preserve the health of the mother?

4). If your clinic only performs abortions after viability when necessary to preserve the life or health of the mother, why do your advertisements state that pregnancy termination is available "through 24th week" without restriction?

Please respond to this office within 30 day [sic] of your receipt of this letter. If you have questions regarding Nebraska law on this subject, you are advised to consult your attorney.

Sincerely yours,

DON STENBERG
Attorney General
/s/ Steve Grasz
Steve Grasz
Deputy Attorney General

Enclosures

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 21

STATE OF NEBRASKA

DEPARTMENT OF HEALTH
Mark B. Horton, M.D., M.S.P.H.
Director

[SEAL]
E. Benjamin Nelson
Governor

October 9, 1996

Mr. Simon Heller
Center for Reproductive
Law and Policy
120 Wall Street
New York, New York 10005

Dear Mr. Heller:

I will look forward to meeting with you and Dr. Leroy Carhart at 10:00 P.M. on Wednesday, October 16, 1996. Please notify me of the location for the interview as soon as arrangements have been made.

Regulatory Compliance investigations has a total of four unresolved case files pertaining to Dr. Carhart's practice. Questions regarding the complaints and issues surrounding these cases will include but may not be limited to the following areas.

1. Questions regarding the number of abortions performed weekly by Dr. Carhart in his last three practice

sites in the Bellevue, Nebraska area, prior to Dr. Carhart receiving a clinic license from the Nebraska Department of Health.

2. Questions regarding Dr. Carhart's administration and dispensing of controlled and non-controlled substances from his last three practice sites, pursuant to his Nebraska Controlled Substance Registration and pharmacy permit, to include questions regarding his record keeping practices involving controlled substances.

3. Questions regarding the physical conditions of Dr. Carhart's office at 1309 Harlan Drive in Bellevue, NE where Dr. Carhart was performing abortions.

4. Questions regarding the sterilization techniques used to process instruments in Dr. Carhart's various locations.

5. Questions regarding the disposal of fetal material following abortion procedures.

6. Questions regarding the nature of services provided by those who assist Dr. Carhart in abortions and questions regarding credentials and/or licensing of those individuals.

7. Questions regarding supervision of physician assistants and monitoring of physician assistant practice and charting.

8. Questions regarding the alleged modification by Dr. Carhart of employment time cards and an employment contract for work done by a physician's assistant formerly employed by Dr. Carhart.

9. Questions regarding the criteria for doing PAP smears and throat cultures on Medicaid patients.

10. Questions regarding the type of abortion procedures Dr. Carhart does at different stages of fetal development.

11. Questions regarding how Dr. Carhart determines fetal viability and an allegation he performs abortions on viable fetuses.

12. Questions regarding placement of Yellow Pages advertising abortions by or on behalf of Dr. Carhart.

13. Questions regarding medical coverage for post abortion patients of Dr. Carhart.

I would expect that my interview may last for approximately 2 to 3 hours. I hope this information will be of value to you. Please do not hesitate to contact me if you require additional information.

Sincerely,

/s/ Duane P. Newland
Duane P. Newland
Investigator
Regulatory Compliance
Investigations
P.O. Box 95164
Lincoln, NE 68509-5164
(402) 471-0175

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 22

(SEAL) STATE OF NEBRASKA

Office of the Attorney General
2115 STATE CAPITOL BUILDING
LINCOLN, NE 68509-8920
(402) 471-2682
TDD (402) 471-2682
CAPITOL FAX (402) 471-3297
1235 K ST. FAX (402) 471-4725

DON STENBERG
ATTORNEY GENERAL

STEVE GRASZ
LAURIE SMITH CAMP
DEPUTY ATTORNEYS
GENERAL

DATE: May 29, 1996

SUBJECT: Constitutionality of a statutory ban on "partial-birth" abortions in Nebraska

REQUESTED BY: Senator Jim Jensen

WRITTEN BY: Don Stenberg, Attorney General
Steve Grasz, Deputy Attorney General

You have requested an Attorney General's opinion as to "whether a ban on partial-birth abortions in the State of Nebraska would be constitutional."

I. Applicable Law

In *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705 (1973), the United States Supreme Court declared that "the unborn"

are not persons, and announced a new fundamental constitutional right to abortion which prevents States from outlawing abortion before viability of the child. 410 U.S. at 147-165, 93 S.Ct. at 724-733. *Roe* established a "trimester" framework governing state regulation of abortion. Under *Roe*, virtually no restrictions could be placed on first trimester abortions. After viability, though, the States could outlaw abortion except where necessary to preserve the life or "health" of the mother. *Id.* at 163-165, 93 S.Ct. at 732-733. The actual ability of States to prohibit abortions after viability was illusory, however, since the "health" exception swallowed the rule. In the companion case of *Doe v. Bolton*, 410 U.S. 179, 93 S.Ct. 739 (1973), the court defined "health" as including psychological, emotional, and familial factors (such as depression, youth, anxiety) as well as physical factors. *Id.* at 192, 93 S.Ct. at 747. Consequently, for all practical purposes, the termination of all pregnancies was a legally protected constitutional right for virtually any reason up until the birth of the child. In fact, in *Schulte v. Douglas*, 567 F.Supp. 522 (D.Neb. 1981), aff'd per curiam sub nom. *Womens Services, P.C. v. Douglas*, 710 F.2d 465 (8th Cir. 1983), the Federal District Court for the District of Nebraska invalidated a Nebraska statute which attempted to prohibit abortion after viability of the child even though the statute allowed postviability abortions that were "necessary to preserve the woman from an imminent peril that substantially endangers her life and health."

Although *Roe v. Wade* has never been overruled, in 1992 the U.S. Supreme Court discarded its arbitrary "trimester" framework, and placed greater emphasis on the States' interest in "potential" life throughout pregnancy.

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 112 S.Ct. 2791 (1992), the Court held that States could regulate pre-viability abortions as long as the regulation did not impose an "undue burden" on the woman. A state statute regulating abortion must have neither "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Planned Parenthood v. Casey*, 112 S.Ct. at 2820-21. *Casey* also lowered the judicial standard applied to state abortion statutes. "After *Casey*, the State need only show that it has a legitimate interest, and that the challenged regulation 'cannot be said [to] serve no purpose other than to make abortions more difficult.' " *Women's Medical Professional Corp. v. Voinovich*, 911 F.Supp. 1051, 1074 n.30 (S.D. Ohio 1995).

The Court clearly stated in *Casey* that after the unborn child reaches viability the State's interest in protecting the fetus outweighs the woman's liberty interest in having an abortion, subject only to a medical determination that an abortion is necessary for the preservation of the life or health of the mother. 112 S.Ct. at 2816-17, 2819-2821. Consequently, "regulations which apply only to post-viability abortions are presumptively valid, unless they have an adverse impact on the life or health of the pregnant woman." *Women's Medical Professional Corp. v. Voinovich*, 911 F.Supp. at 1060.

Most significantly perhaps, the Court in *Casey* upheld a definition of "medical emergency" in a Pennsylvania statute which limited the physician's determination to consideration of *physical* health factors. 112 S.Ct. at 2822. The Supreme Court further stated, albeit in dicta, that it is only in "rare circumstances in which the pregnancy is

itself a danger to [the woman's] own life or health." 112 S.Ct. at 2806. If the Supreme Court meant what it said in *Casey*, then laws prohibiting post-viability abortions except where necessary to preserve the life and physical health of the mother are constitutional. If on the other hand, "health" is still an all-inclusive term, the Supreme Court's statements are mere legal sophistry, serving only to obscure the fact that babies' brains may still legally be suctioned out of their heads (as in partial-birth abortions) for virtually any reason. In fact, a federal district court recently held that "a state may not constitutionally limit the provision of abortion only to those situations in which a pregnant woman's physical health is threatened, because this impermissibly limits the physician's discretion to determine what measures are necessary to preserve her health." *Women's Medical*, 911 F.Supp. at 1081. Consequently, it is not clear whether "health" may be limited to physical factors. If not, the ability of States to proscribe abortions even after viability remains as illusory today as it was between 1973 and 1992. Nonetheless, the State of Nebraska is legally entitled to rely on the *Casey* decision until and unless a court of competent jurisdiction directs otherwise.

In sum, a total ban on "partial-birth abortions", especially since it would encompass both pre-viability and post-viability abortions, would likely have to pass the "undue burden" test of *Casey*.[1] Under *Casey*, "a state may

[1] Some legal scholars have argued that a less stringent test should be applied by reviewing courts due to the distinguishable features of a partial-birth abortion ban as compared to other abortion restrictions considered by the U.S.

act to prohibit a method of abortion, if there are safe and available alternatives." *Women's Medical*, 911 F.Supp. at 1067. In *Women's Medical*, the court framed the issue as "whether . . . there are safe and available alternatives to the D & X procedure, which is typically performed during the twentieth to twenty-fourth weeks of pregnancy, such that there would be no undue burden if the procedure were banned." *Id.*[2]

Supreme Court. *See* Hearings on HR 1833 Before the Senate Judiciary Committee, 104th Cong., 1st Sess. (Nov. 17, 1995) (testimony of David M. Smolin, Prof. of Law, Cumberland Law School, Samford University) transcript at pp. 344-350; Hearings on HR 1833 Before the Senate Judiciary Committee, 104th Cong., 1st Sess. (Nov. 17, 1995) (testimony of Douglas W. Kmiec, Prof. of Constitutional Law, University of Notre Dame), transcript at pp. 172-187 These arguments appear to have merit, and would likely be pursued in any litigation arising as a result of adoption of legislation banning partial-birth abortions. However, for purposes of this opinion, we will proceed under the most restrictive possible constitutional test.

[2] This opinion expresses no view as to the proper judicial standard for adjudicating a "facial" challenge to the constitutionality of an abortion statute, as opposed to a challenge to a statute "as applied". Since *Casey*, a split has developed among the circuit courts as to whether the approach taken in *Casey* has replaced the standard in *United States v. Salerno*, 481 U.S. 739 (1987). The Eighth Circuit has concluded that *Casey* did replace *Salerno*. *See Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1458 (8th Circuit 1995). However, in separate (and unusual) memoranda accompanying an order denying a writ of certiorari in this same South Dakota case, two Justices of the Supreme Court took differing views of this issue. Justice Scalia stated that this question "virtually cries out for our review." *Janklow v. Planned Parenthood*, 1996 WL 203346 (U.S.) (Scalia, J., dissenting) (April 29, 1996). It is possible, therefore, this issue will eventually be taken up by the Court in

II. Analysis

Because the answer to your question ultimately hinges on medical facts (i.e. whether there are "safe" and available alternatives to the partial-birth or D & X abortion procedure), it is essential to define the procedure and its alternatives. This opinion will not attempt to define all the available alternatives, but will discuss several relevant procedures.

A. Definition of Abortion Procedures

1. Partial-birth/D & X Abortions

The procedure referred to in your request ("partial-birth abortion") is also sometimes known as a "Dilation and Extraction". ("D & X") abortion. *See Women's Medical*, 911 F.Supp. at 1063; *Family Planning Specialists v. Powers*, 46 Cal.Rptr.2d 667, 668 (Cal.App. 1995). This procedure involves partial dilation of the woman's cervix; pulling the baby's feet and entire body out through the birth canal up to the baby's neck; piercing the baby's skull with a sharp instrument; insertion of a tube into the brain; removal of the brain by suction; collapse of the skull; and removal of head. The baby (usually 20-24 weeks old) may or may not be alive and kicking at the time his or her skull is pierced and brains are suctioned out.[3]

Women's Medical Professional Corp. v. Voinovich, 911 F.Supp. 1051 (S.D. Ohio 1995) (currently on appeal to the 6th Circuit), in which this issue was also litigated.

[3] Allegedly, some abortionists kill the baby by other means before the brain is removed. For example, one doctor says he cuts the baby's umbilical cord, and the baby dies before the procedure is performed. It reportedly "takes eight to ten minutes for the fetus to die, following the cutting of the umbilical cord." *Women's Medical*, 911 F.Supp. at 1066 n. 17. However, the same doctor told the American Medical News that two-thirds of the fetuses are alive when he performs the procedure. *See* Hearings on H.R. 1833 Before the Senate Judiciary Committee, 104th Cong., 1st Sess. Transcript at p. 23.

a. Haskell D & X

The best-known practitioner of this procedure is Dr. Martin Haskell. His D & X abortion procedure has been described as follows:

> On the first and second days of the procedure, Dr. Haskell inserts dilators into the patient's cervix. On the third day, the dilators are removed and the patient's membranes are ruptured. Then, with the guidance of ultrasound, Haskell inserts forceps into the uterus, grasps a lower extremity [foot and leg], and pulls it into the vagina. With his fingers, Haskell then delivers the other lower extremity [foot and leg], the torso, shoulders, and the upper extremities [arms]. The skull, which is too big to be delivered, lodges in the internal cervical os. Haskell uses his fingers to push the anterior cervical lip out of the way, then presses a pair of scissors against the base of the fetal skull. He then forces the scissors into the base of the skull, spreads them to enlarge the opening, removes the scissors, inserts a suction catheter, and evacuates the skull contents [brain]. With the head decompressed, he then removes the fetus completely from the patient.

Women's Medical, 911 F.Supp. at 1066 (bracketed material added). Dr. Haskell has stated that about 80% of the D &

X abortions he performs between 20 and 24 weeks "are purely elective." *See* Hearings on H.R. 1833 Before the Senate Judiciary Committee, 104th Cong., 1st Sess (Nov. 17, 1995) Transcript at p.13.[4]

b. Ohio Statutory Definition

In the State of Ohio, Dilation and Extraction abortion (D & X or partial-birth abortion) has been statutorily defined at follows:

> [T]he termination of a human pregnancy by purposely inserting a suction device into the skull of a fetus to remove the brain. 'Dilation and extraction procedure' does not include either the suction curettage procedure of abortion or the suction aspiration procedure of abortion.

O.R.C. § 2919.15(A) (The Ohio statute bans this procedure except where "all other available abortion procedures would pose a greater risk to the health of the pregnant women.").

c. Congressional Definition

The United States Congress defined partial-birth abortion as follows:

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[4] We note that recent media reports in Nebraska concerning this procedure have not always described partial-birth abortions accurately. Several articles have stated that "the physician uses an instrument to pierce and drain the skull." The skull is not "drained". Rather, the brains are suctioned out. Use of the word "drained" is a factually inaccurate euphemism. The scientific reality is that the fetus or unborn child's brains are sucked out during what would otherwise constitute delivery.

> "partial-birth abortion" means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery. The Congressional bill excepted partial-birth abortions "necessary to save the life of a mother whose life is endangered by a physical disorder, illness or injury: Provided, that no other medical procedure would suffice for that purpose.

Partial Birth Abortion Ban Act of 1995 (H.R. 1833, as amended by the Senate Amendments. Congressional Record H 11604 (Nov. 1, 1995) and H 2905 (March 27, 1996)). *See also Sabelko v. City of Phoenix*, 68 F.3d 1169, 1174 n.1 (referencing Senate debate) ("the abortionist takes a pair of scissors and inserts the scissors into the back of the skull and then opens the scissors up to make a gap in the back of the skull in order to insert a catheter to literally suck the brains from the back of that child's head. That is what happens in the so-called partial-birth abortion.").

2. Dilation & Evacuation Abortions

Another type of abortion is known as dilation and evacuation or D & E. *See Women's Medical*, 911 F.Supp. at 1064. This procedure was described in that case in some detail by the United States District Court for the Southern District of Ohio as follows:

> In the second trimester, the fetus becomes too large to remove by use of suction curettage. At that point, the most common abortion method is a Dilation and Evacuation (D & E) procedure; indeed, it is the only procedure

which can be used from the thirteenth to sixteenth weeks of pregnancy. Instead of using metal rods to dilate the cervix over a short period of time, the doctor inserts laminaria into the cervix during the one-to-two day period prior to the procedure, in order to slowly dilate the cervix. Then, a suction curette with a larger diameter is placed through the cervix, and the doctor removes some, or all, of the fetal tissue.

Frequently, however, the torso and the head cannot be removed in this manner. The procedure typically results, therefore; in a dismemberment of the fetus, beginning with the extremities. This dismemberment is accomplished both by use of the suction curettage, and by the use of forceps [the arms and legs are cut off or pulled off].

Removing the head of the fetus from the uterus is typically the most difficult part of the D & E procedure, in part because the head is often too large to fit through the partially dilated cervix. It is important to remove the head as quickly as possible, because fetal neurologic tissue can negatively affect the mother's ability to clot, and lead to greater bleeding. Physicians have developed different methods of decompressing the head, in order to remove it.

Dr. Anthony Levatino testified that when he performed D & E abortions, he preferred to grasp the fetal head with a clamp, crush it, and remove it in pieces along with the skull contents. Because he decompressed the skull by crushing it, he found it unnecessary to decompress the skull by purposely inserting a suction device into the skull and removing some of its contents.

Dr. Paula Hillard testified that when the skull is too large to remove intact, she grasps the skull and suctions out its contents with a cannula – which may enter the skull – in order to decompress it and facilitate its removal. . . .

Dr. Doe Number One testified that because the use of forceps can cause trauma to the mother's uterus, his preference is to collapse the head by use of suction, prior to its removal. By making a small incision at the base of the skull and inserting a suction device into the brain – while the head is still within the uterus, and no longer attached to the body – he can collapse the head and easily remove it, without the use of forceps. This method decreases injury to the cervix and uterus, and reduces operating room time, blood loss, and anesthesia time. Dr. Doe describes his procedure as a D & E, and collapses the head by the use of suction even in procedures performed from 15 to 18 weeks. . . .

Dr. Mary Campbell has not performed second-trimester abortions, but has read about and observed various second-trimester methods, in preparation for setting up a second-trimester practice at her clinic. In describing the D & E procedure, she testified that the fetal skull is generally not intact following dismemberment of the body – the jaw is often removed with the neck – and "the edges of the fetal skull are sharp enough to lacerate the maternal uterine [blood] vessels. . . . " The goal is therefore to place the suction cannula into the skull in order to remove its contents and make it smaller, thereby allowing it to be removed intact, in order to minimize lacerations. In addition, removing the head intact is advantageous because it ensures that no

parts of the skull are left behind in the woman's uterus.

. . .

The primary distinction between this D & X procedure and the D & E procedure previously described appears to be that, whereas the D & E procedure results in dismemberment and piece-by-piece removal of the fetus from the uterus – and, possibly, in removal of portions of the skull contents by the use of suction after the skull is crushed with forceps or otherwise invaded, and before the head is placed next to the opening to the uterus – the D & X procedure results in a fetus which is removed basically intact except for portions of the skull contents which are suctioned out after the head is placed next to the opening to the uterus (and after the rest of the fetus is removed from the uterus), and before the fetus is fully removed from the mother's body. The hallmark of the D & X procedure, therefore, is that the fetus is removed intact, rather than being dismembered prior to removal, as is done in a D & E procedure. In both procedures, the head usually must be decompressed, either by crushing the skull, or by invading the skull and suctioning out its contents. In the D & X procedure, the suctioning is purposeful; in a D & E procedure, the suction may either be purposeful, or, given the inability to clearly see the fetus, even with ultrasound, and the consequent difficulty of knowing whether the surgical instrument is in, or simply near, the skull, it may be accidental.

Women's Medical, 911 F.Supp. at 1064-66 (emphasis and bracketed material added).

The court in *Women's Medical* concluded that "Assuming that the D & X procedure is 'cruel,' however, this Court fails to see how it is more cruel than the D & E procedure – which involves the dismemberment of the fetus and, sometimes, the crushing of its skull. . . . " 911 F.Supp. at 1074 n. 29. The D & E abortion procedure is the most common abortion procedure in the second trimester (after 13 weeks).

3. Instillation/Induction Procedures

The court, in *Women's Medical*, also described a procedure known as instillation/induction.

> The main alternative to the D & X procedure, in the late second trimester, is the use of an induction method of abortion. Induction methods are also known as "instillation" methods. In one type of induction method, the physician injects some substance – typically saline, or a combination of a prostaglandin and urea – into the amniotic cavity of the woman. In another type, the physician places prostaglandin suppositories into the patient's vagina. In both cases, the end result is labor: the substances cause the uterus to contract, resulting in the eventual expulsion of the fetus. This labor typically lasts between twelve and twenty-four hours, but may last as long as thirty-six hours.

Id. at 1068.

B. Availability of Other Procedures

Under the undue burden test in *Casey*, in order for a statute banning partial-birth abortions to be upheld it is

necessary to show that there are "safe" alternative abortion procedures available. *Women's Medical*, 911 F.Supp. at 1067. The court in *Women's Medical* concluded there are not:

> After viewing all of the evidence, and hearing all of the testimony, this Court finds that use of the D & X procedure in the late second trimester appears to pose less of a risk to maternal health than does the D & E procedure, because it is less invasive – that is, it does not require sharp instruments to be inserted into the uterus with the same frequency or extent – and does not pose the same degree of risk of uterine and cervical lacerations, due to the reduced use of forceps in the uterus, and due to the removal of any need to crush the skull and remove it in pieces, which can injure maternal tissue.
>
> This Court also finds that the D & X procedure appears to pose less of a risk to maternal health than the use of induction procedures, which require the woman to go through labor, pose additional risks resulting from the injection of fluids into the mother, and cannot be used for every woman needing an abortion.
>
> Finally, the Court finds that the D & X procedure appears to pose less of a risk to maternal health than either a hysterotomy or a hysterectomy, both of which are major, traumatic surgeries.
>
> Because the D & X procedure appears to have the potential of being a safer procedure than all other available abortion procedures, this Court holds that the Plaintiff has demonstrated a substantial likelihood of success of showing that the state is not constitutionally permitted to

> ban the procedure. If this abortion procedure, which appears to pose less of a risk to maternal health than any other alternative, were banned, and women were forced to use riskier and more deleterious abortion procedures, the ban could have the effect of placing a substantial obstacle in the path of women seeking pre-viability abortions, which would be an undue burden and this [sic] unconstitutional under *Casey*.
>
> Even if induction procedures were as safe as the D & X procedure – and this Court does not find, on the evidence, that they are as safe – the requirement that a pregnant woman be hospitalized in order to undergo an induction procedure may also have a negative impact on the practical availability of abortions for women seeking pre-viability abortions. First, hospitals may refuse to allow induction procedures on an elective basis, including those situations in which a woman wishes to abort a fetus with severe anomalies. Second, it may be psychologically daunting to undergo the induction procedure in the hospital environment. These practical problems may discourage women in their second trimester from exercising their right of seeking elective, previability abortions, or make it practically impossible to do so, thereby amounting to an undue burden on the right to seek a pre-viability abortion. In contrast, the D & X procedure can be performed on an outpatient basis within a much shorter period of time, and is not limited by either of these practical problems.
>
> For both of these reasons – because the D & X procedure appears to be the safest method of

> terminating a pregnancy in the late second trimester, and because the D & X procedure is more available than induction methods, which require the woman to be hospitalized – this Court holds that Plaintiff has demonstrated a substantial likelihood of success of showing that the ban on the D & X procedure is unconstitutional under *Danforth* and *Casey*.

Id. at 1070-1071.

As is evident from the above-quoted portions of the opinion, the court in *Women's Medical* refused to give legal significance to the fact that under the Ohio statute, the D & X or partial-birth abortion procedure is *not* prohibited where "all other available abortion procedures would pose a greater risk to the health of the pregnant woman than the risk posed by the dilation and extraction procedure." *See* O.R.C. 2919.15(C)(1). This point will likely be argued by the State of Ohio on appeal, as *Women's Medical* is now before the 6th Circuit Court of Appeals (We have obtained and reviewed the briefs from that appeal in preparing this opinion).

Although the findings of the District Court for the Southern District of Ohio are, apparently, the only judicial findings currently available, they are not controlling on Nebraska courts or even necessarily persuasive. We have also reviewed testimony provided to the Congress of the United States by medical experts.

During the U.S. Senate's consideration of H.R. 1833 last November, Nancy G. Romer, M.D. testified before the Senate Judiciary Committee on the medical aspects of partial-birth abortion. Dr. Romer is a practicing obstetrician and gynecologist in Dayton, Ohio and is a diplomat

of the American Board of Obstetrics and Gynecology. She is a fellow of the American College of Obstetrics and Gynecology as well as a clinical professor in the Department of Obstetrics and Gynecology at Wright State University and vice chairman of the Department of Obstetrics and Gynecology of Miami Volley [sic] Hospital in Dayton.

Dr. Romer testified that "In my medical judgment this procedure [D & X or partial-birth abortion] offers no advantage in safety nor efficacy over other methods of termination . . . [I] n my medical judgment, legislation to prohibit the D & X procedure or partial birth abortion does not present a substantial barrier to women seeking late term abortion. There is no medical evidence that this procedure is safer nor necessary to provide comprehensive health care to women. As currently practiced, it does not meet medical standards set by ACOG nor has it been adequately proven to be safe or efficacious." Hearings on H.R. 1833 Before the Senate Judiciary, 104th Cong., 1st Sess. (Nov. 17, 1995) Transcript at p. 112.

We also note that a recent article in the *Washington Times* quotes Dr. Frank Boehm, Director of Obstetrics at Vanderbilt University Medical Center in Nashville, as saying there are "no medical circumstances in which a partial-birth abortion is the only safe alternative." Dr. Frank Boehm, Partial-Birth Abortion Stirs A Medical Debate, Wash. Times, May 6, 1996. Thus, notwithstanding the decision of one judge in Ohio, it appears that substantial evidence could be presented that "safe" alternatives exist to partial-birth abortion.

III. Conclusion

It is essential to keep in mind that the D & X or "partial-birth" abortion ban being challenged in *Women's Medical* is a specific Ohio statute that may be subject to challenges not applicable to a Nebraska statute with different provisions. The Ohio statute apparently covers all abortions involving "inserting a suction device into the skull of a fetus to remove the brain." This fact seemed to play heavily in the decision of the federal district court. In contrast, the partial-birth abortion ban passed by the United States Congress (HR 1833) (and vetoed by President Clinton) banned only abortions in which a living fetus is partially delivered and then killed before delivery is completed.

Thus, it appears that while Ohio has attempted to ban all abortions which involve purposely sucking the brains out of unborn babies, the U.S. Congress attempted only to ban such abortions where the baby is still alive at the time the skull is pierced and the suction tube is inserted in the brain. Many or all of the objections of the District Court in the *Women's Medical* case (whether valid or not) would seem to disappear in the context of the Congressional approach. This conclusion, however, brings to mind the comment of the District Court of Ohio that cutting the arms and legs off a "fetus" inside the mother and crushing its head with forceps (as is done routinely in abortion clinics after 12 weeks in D & E abortions) is arguably no less cruel than sucking a baby's brains out after it is partially delivered.

Degree of cruelty is not the issue here, however. The legal issue presented is whether partial-birth abortions

can constitutionally be banned. The answer is clearly yes, provided the statute does not impose an "undue burden" on women seeking abortions before viability of the fetus. A more specific, and less circular answer, is that it is inconceivable to us that a statute requiring the abortionist to kill the baby *before* its brains are sucked out would place any "undue burden" on women that even the U. S. Supreme Court could identify. A statute which bans all suctioning of brains, however, would be more difficult to uphold given the current state of the law, since it could possibly encompass some D & E abortions if they are not specifically excluded in the statute. However, if evidence shows that suctioning of the brains of living fetuses is never medically necessary, it could be banned outright. The federal district court's decision in southern Ohio has no legal force in Nebraska.

Finally, we would be remiss if we did not state the obvious: The legal question presented by the examination of the constitutionality of partial-birth abortion legislation is so inherently macabre, and utterly divorced from moral or rational foundation that it undermines the credibility of the legal system, and necessarily exposes the moral bankruptcy which is the legacy of *Roe v. Wade*. As the federal district court in *Women's Medical* recently stated, "Never, since the final shot of the Civil War, over a century and a quarter ago, has American society been faced with an issue so polarizing and, so totally incapable of . . . compromise, as is the ongoing controversy, of which this case is but the latest chapter, over the legality of attempts by the State to regulate abortion – the act of voluntarily terminating a pregnancy, prior to full term." *Women's Medical*, 911 F.Supp. at 1056.

Under the current state of Nebraska law, human fetuses or unborn babies are literally afforded less legal protection against cruelty, including dismemberment and death, than stray cats or rodents. It would be a criminal offense under Nebraska law to cut off the limbs of a cat or suck the brains out of a living rat merely to kill it, as is done in partial-birth abortions. *See* Neb. Rev. Stat. S 28-1008, 1009 (1994 Supp.). In contrast, unborn babies, who at 19 weeks can be felt kicking through their mother's body (externally) and who can be seen sucking their thumbs on ultrasound, can legally have their limbs cut off and their skulls crushed with forceps in D & E abortions (which are not the subject of partial-birth abortion legislation) or have their brains sucked out during what would otherwise constitute delivery by a D & X or partial-birth abortion. *See Women's Medical*, 911 F.Supp. at 1065 (discussing testimony of Dr. Harlan Giles, who performs D & E abortions up to the 20th week of pregnancy). This is the legal and medical reality of *Roe v. Wade* and *Planned Parenthood v. Casey*.

In sum, we believe that a partial-birth abortion statute could be drafted that would meet constitutional requirements under applicable decisions of the United States Supreme Court. We note that if the goal of such legislation is to prevent cruelty to late-term fetuses (as was the intent in Ohio), then amendments should also be made to Nebraska's existing statute regulating post-viability abortions (as was done by the Ohio Legislature) since the existing statute may permit other equally cruel abortion procedures to be performed on viable unborn babies. Any statutory changes must, of course, be carefully structured to meet the criteria of *Planned Parenthood*

v. Casey, and should be accompanied by specific statements of legislative intent.

Sincerely yours,

DON STENBERG
Attorney General

/s/ Steve Grasz
Steve Grasz
Deputy Attorney General

Approved by:

/s/ Don Stenberg
Attorney General

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 23

January 22, 1998

CURRICULUM VITAE

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Nashville, Tennessee

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PERSONAL DATA:

Marital Status:
Married – Julie Goldstein Boehm

Children:
Todd Edward – January 30, 1967

Thomas Ludwig – June 10, 1968

Catherine Valerie – September 2, 1980

Military Service:

1970-1972

LCDR Navy Chief, Department of
Obstetrics and
Gynecology
Bainbridge Naval Training Center
Bainbridge, Maryland

EDUCATION:

1962	B. A. Vanderbilt University Nashville, Tennessee
1965	M. D. Vanderbilt University Nashville, Tennessee

POSTGRADUATE TRAINING:

1965-1966	Internship, Surgery Yale-New Haven Hospital New Haven, Connecticut
1966-1968	Assistant Resident, Obstetrics and Gynecology Yale-New Haven Hospital New Haven, Connecticut
1968-1969	Associate Resident, Obstetrics and Gynecology Yale-New Haven Hospital New Haven, Connecticut
1969-1970	Resident, Obstetrics and Gynecology Yale-New Haven Hospital New Haven, Connecticut
July-Dec. 1969	Fellowship, Surgery and Oncology City of Hope Duarte, California

LICENSURE AND CERTIFICATION:

Tennessee	1965
National Medical Board Exam Certification	1966
Diplomate-National Board of Medical Examiners	1966
Diplomate-American Board of Obstetricians/Gynecologists	1973
Diplomate-American Board of Obstetricians and Gynecologists, Certificate of Special Competence in Maternal/Fetal Medicine	1976

ACADEMIC APPOINTMENTS:

1966-1969 Teaching Assistant, Obstetrics and Gynecology
Yale-New Haven Hospital
New Haven, Connecticut

1969-1970 Instructor, Obstetrics and Gynecology
Yale-New Haven Hospital
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1970-1972 Chief, Obstetrics and Gynecology
Bainbridge Naval Training Center
Bainbridge, Maryland

1972-1975 Assistant Professor, Obstetrics and Gynecology
Vanderbilt University Hospital
Nashville, Tennessee

1972- Director, Fetal Intensive Care Unit
Vanderbilt University Hospital
Nashville, Tennessee

1975-1981 Associate Professor, Obstetrics and Gynecology
Vanderbilt University Hospital
Nashville, Tennessee

1976-1991 Associate Clinical Professor
Obstetrics and Gynecology
Meharry Medical College
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1978-1980 Co-Director, Maternal/Fetal Medicine Division
Vanderbilt University Hospital
Nashville, Tennessee

1980- Director, Maternal/Fetal Medicine Division
Vanderbilt University Hospital
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1981- Professor, Obstetrics and Gynecology
Vanderbilt University Hospital
Nashville, Tennessee

1982- Associate Professor, Radiology
Vanderbilt University Hospital
Nashville, Tennessee

1991- Clinical Professor
Obstetrics and Gynecology
Meharry Medical College
Nashville, Tennessee

HOSPITAL APPOINTMENTS:

1972- Vanderbilt-University Hospital
Nashville, Tennessee

1972-1976 Saint Thomas Hospital, Medical Staff
Nashville, Tennessee

1972-1992 Nashville General Hospital, Medical Staff
Nashville, Tennessee

1972- State Consultant to Perinatal Division of Public Health Department
Nashville, Tennessee

1973-1978 Obstetric Consultant
Florence Crittenton Home for Unwed Mothers
Nashville, Tennessee

1974-present Baptist Hospital, Medical Staff
Nashville, Tennessee

1979-1982 Consultant, Veterans Administration Hospital
Nashville, Tennessee

1983-1987 Obstetric Consultant to Hospital Corporation of America

1986- Clinical and Research Associate
The Center for Clinical and Research Ethics
Vanderbilt School of Medicine

1986-1992 Active Staff; Obstetrics and Gynecology
Hubbard Hospital/Meharry Medical College
Nashville, Tennessee

1995- Centennial Hospital
Nashville, Tennessee

1995- Saint Thomas Hospital
Nashville, Tennessee

PROFESSIONAL ORGANIZATIONS:

American College of Obstetricians and Gynecologists, Fellow

Association of Professors of Gynecology and Obstetrics

Central Association of Obstetricians and Gynecologists

The Clinical Ethics Guild

Davidson County Foundation for Medical Care

Davidson County Medical Society

Nashville Academy of Medicine

Society of Perinatal Obstetricians

Tennessee Obstetricians and Gynecologists Society

Tennessee Perinatal Association

American Institute of Ultrasound in Medicine

Julia Hereford Society Board

The Lonnie Burnett Society

OFFICES HELD:

1980 President Elect, Southern Perinatal Association

1981 President, Southern Perinatal Association

PROFESSIONAL ACTIVITIES:

INTRAMURAL:

1972-1980 Course Instructor – "Human Sexuality"
Vanderbilt University Medical School

1980-1989 Chairman, Third and Fourth Year Medical School Promotions Committee Vanderbilt University School of Medicine

1980- Fund Raiser, Maternal-Fetal Medicine Division Vanderbilt University Medical Center

1981-1984 Co-Director, Genetic Center Vanderbilt University Medical Center

1983-1985 Vanderbilt Hospital Board

1984 Continuing Medical Education Committee Vanderbilt University Medical School

1986-1988 Executive Committee of the Hospital Medical Board Vanderbilt University Hospital

1985- Member, Medical Ethics Committee Vanderbilt University Hospital

1987- Co-Chairman, Perinatal Advisory Committee Vanderbilt University Hospital

1988-1991 Member, University Promotion and Tenure Review Committee Vanderbilt University Hospital

1990-1991 Chairman, Medical Center Faculty/Staff Campaign Vanderbilt University Medical Center

1990-1992 Chairman, Partners in Health Campaign, Vanderbilt University Medical Center

1990- Chairman, Hospital Medical Ethics Committee Vanderbilt University Hospital

1990-1994 Member, Board of Directors Canby Robinson Society Vanderbilt University Medical Center

1992-1993 Member, Academic Programs Committee Vanderbilt University School of Medicine

1992 Member, United Way Committee Vanderbilt University

1993-1995 Member, Networking Committee Vanderbilt University Medical Center

1993- Member, Board, Julia Hereford Society Vanderbilt University School of Nursing

1994 Member, United Way Committee Vanderbilt University Medical Center

1995 Member, Cal Turner. Ethics Scholar Search Committee

EXTRAMURAL

1975- Perinatal Advisory Committee State of Tennessee

1975-1980 Regionalization Coordinator State of Tennessee

1976-1977 Board of Directors, The American Society for Psycho-Prophylaxis in Obstetrics, Inc. Nashville Chapter

1976-1980 Board of Directors, March of Dimes Music City Chapter Nashville, Tennessee

1978 Chairman, Legislative Review Committee Southern Perinatal Association

1978-1979 Chairman, Legislative Committee National Perinatal Association

1979-1989 Staff, Maternal Mortality Committee State of Tennessee

1979 Consensus Development Workshop Sickle Cell Disease Branch National Institutes of Health

1979-1981 Feasibility Study Committee on Sickle Cell Disease National Institutes of Health

1981- Medical-Legal Expert Consultant

1981-1983 Tennessee Malpractice Review Board

1982-1983 Advisor-Symposia Medicus

1982-1988	Board of Directors Tennessee Perinatal Association
1984	Board of Directors Nashville Human Sexuality Council
1984	Grant Review for Chorionic Villus Sampling National Institute of Child Health and Human Development
1985-1988	American College of Obstetricians and Gynecologists Member, Committee on obstetrics: Maternal and Fetal Medicine
1986-1987	American College of Obstetricians and Gynecologists Member, American Academy of Pediatrics Committee on Drugs
1987-1990	Chairman, Legislative Committee of Society of Perinatal Obstetricians
1986-1988	Member, Pediatric Chairman Search Committee
1986-1989	Board of Directors Society of Perinatal Obstetricians
1987-1988	Member, Legislative Workshop, American College of Obstetricians and Gynecologists
1994	Member of International Advisory Committee First World Congress on Labor and Delivery Jerusalem, Israel, July 3-7, 1994
1995	Member, Governor's Appointed TennCare Roundtable
1995	Member, NICHD Task Force on Electronic Fetal Monitoring
1995	Member, Governor's Appointed Graduate Medical Education Task Force

1996	Chair, Tennessee State Task Force on 48 Hour Legislation

EDITORIAL CONSULTANT:

American Journal of Obstetrics. and Gynecology

Journal of the American Medical Association

Journal of Obstetrics and Gynecology

New England Journal of Medicine

Southern Medical Journal

Journal of Clinical Ethics

International Journal of Gynecology & Obstetrics

VISITING PROFESSORSHIP:

July, 1983	Visiting Professor Carmel Hospital Haifa, Israel

ACADEMIC OR PROFESSIONAL HONORS:

Mead Johnson Award for Graduate Teaching

Second Prize, Research Award, District VII, American College of Obstetricians and Gynecologists, 1973 and 1974

Named in *The Best Doctors in America* (Woodward-White, Inc., 1992-1993, 1994-1995 editions), based on national peer recommendations Best Student Teacher, Association of Professors of Gynecology and Obstetrics

Honored at 1993 Roundtable Dinner for Outstanding Educators, Nashville, Tennessee

Named in *The Best Doctors in America: Midwest Region 1996-1997*

Named in Best Internet Sites by *The Nashville Scene*: Doctors Cry Too; hetp://dr-boehm.com

Named in *Good Housekeeping* magazine as one of the country's best doctors for women, August 1997.

OTHER SIGNIFICANT ACTIVITIES:

Member of The Jewish Temple and West End Synagogue

Religious School Teacher, 9th grade, 1980-1985 "Jewish Debate and Dilemmas"

Fund Raiser – Jewish Welfare Fund

Board of Trustees, The Temple, Nashville, Tennessee Chairman, Jewish Outreach Committee, The Temple, Nashville, Tennessee Regular columnist for The (Nashville) *Tennessean*, The (Boca Raton, Florida) *News and MD News* (national magazine for physicians):

"Healing words," presenting medical issues to the general public, 1992-present.

Chairman, Committee Relations Committee, Jewish Federation of Middle Tennessee, 1994-

Board of Directors, Jewish Federation of Middle Tennessee, 1994-

Board of Trust, Harpeth Hall Girl's School of Nashville, 1995-

Southeast Regional Board Anti-Defamation League, 1996

Senator Bill Frist Roundtable Advisor/Member

Executive Council Member, Council Jewish Public Affairs, 1996-present

Board of Directors, Helios Inc., 1996-present

Co-Chair, "Nashville Celebrates Israel's 50th Birthday", project of Jewish Federation, 1998.

OTHER HONORS:

Man of the Year – CABLE (Business Women's organization), 1980.

RESEARCH PROGRAM:

1972	Principal Investigator, Arthur Frank Fund to Vanderbilt University Medical Center to Establish Fetal Intensive Care Unit.
1973-1975	Principal Investigator, Medical Program High-Risk Obstetrics Project Nashville, Tennessee
1973	Principal Investigator, Upjohn Pharmaceutical Company Grant Induction of Labor in Pregnant Women with Orally Administered Prostaglandins
1974-1976	Principal Investigator, Public Health Department, Research Grant to Study Obstetric Regionalization
1975-1976	Principal Investigator, March of Dimes – Middle Tennessee Obstetric Education Grant 1976 Principal Investigator, Syntex Pharmaceutical Company Grant Naproxen in the Treatment of Dysmenorrhea
1976-1977	Participant, National Collaborative Study of Electronic Fetal Stress Testing Long Beach, California
1978-	Principal Investigator Middle Tennessee Obstetric Regionalization Project
1981-1985	Principal Investigator Fetal Monitor Evaluation Litton Monitoring Company Grant Award
1982-1986	Principal Investigator Tennessee Prenatal Program

1982-1987 Consultant, March of Dimes Prevention of Prematurity Study

1983-1986 Principal Investigator Autocorrelation in Fetal Monitoring Hewlett Packard Company Grant Award

1989-1991 Principal Investigator, March of Dimes Prevention of Prematurity Study

1995- Principal Investigator, Nellcor Multicenter Study: Pulse Oximeter Evaluation of Fetal Status

1996- Principal Investigator, TennCare Study on Impediments to Pregnancy Care in Middle Tennessee

CURRENT RESEARCH TOPICS:

Sinusoidal Fetal Heart Rate

Fetal Stress vs Distress

Fetal Pulse Oximetry

PUBLICATIONS:

1. Reynolds VH, Boehm FH, Cohen S: Enhancement of chemical carcinogenesis by an epidermoid growth factor. *Surg Forum* XVI:108-9, 1965.
2. Killen DA, Edwards R, Adkins RB Jr, Boehm FH: Spinal cord ischemia following mobilization of canine aorta from posterior parietes. *Ann Surg* 162:1063-7, 1965.
3. Maudsley R, Boehm FH: Erythrocytosis associated with a fibroid uterus. *Can Med Assoc J* 103:517-8,1970.
4. Boehm FH, Pruett K, Zamore L: Ruptured dermoid cyst in labor stimulating abruptio placenta. *J Reprod Med* 6:229-31, 1970.

5. Boehm FH, Morris. JM: Paget's disease and apocrine gland carcinoma of the vulva. *Obstet Gynecol* 38:185-92, 1971.
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7. Acker D, Boehm FH, Askew D: ECG changes with IUD insertions. *Am J Obstet Gynecol* 115:458-61, 1973.
8. Blath R, Boehm FH: Carcinoma of the female urethra. *Surg Gynecol Obstet* 136:1-4, 1973.
9. Boehm FH, Srisupundit S, Ishii T: Lecithin and sphingomyelin ratio and a rapid test for surfactant in amniotic fluid: A comparison. *Obstet Gynecol* 41:829-32, 1973.
10. Boehm FH, Goss DA: The Xerox telecopier and the fetal monitor. *Obstet Gynecol* 42:475-8, 1973.
11. Boehm FH, DiPietro DL, Goss DA: The effect of ampicillin administration on urinary estriol and serum estradiol in the normal pregnant patient. *Am J Obstet Gynecol* 119:98-103, 1974.
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14. Boehm FH: Spontaneous hypertonic uterine contractions. *Tenn Med J* 67:660-2, 1974.
15. Boehm FH: The fetal intensive care unit:. An evolving concept. *South Med J* 67:1145-9, 1974.
16. Boehm FH, Growdon JH Jr: The effect of eclamptic convulsions on the fetal heart rate. *Am J Obstet Gynecol* 120:851-2, 1974.

17. Boehm FH, Growdon JH Jr: The effect of scopolamine on fetal heart rate baseline variability. *Am J Obstet Gynecol* 120:1099-104, 1974.

18. Boehm FH, Hodge SJ: Regionalization of a fetal monitoring system. *J Tenn Med Assoc* 68:13-14, 1975.

19. Boehm FH: Prolonged end stage fetal heart rate deceleration. *Obstet Gynecol* 45:579-82, 1975.

20. Boehm FH, Sarratt H: Indomethacin for the treatment of dysmenorrhea: A preliminary report. *J Reprod Med* 15:84-6, 1975.

21. Boehm FH, Woodruff LF Jr, Growdon JH Jr: The effect of lumbar epidural anesthesia on fetal heart rate baseline variability. *Anesth Analg* 54:779-82, 1975.

22. Woodruff LF Jr, Herbert WNP, Ishii T, Boehm FH: Clinical usefulness of the lecithin/sphingomyelin ratio determined by visual means in predicting hyaline membrane disease. *J Tenn Med. Assoc* 69:330-3, 1976.

23. Boehm FH, Hodge SJ, Shaffer FH: Induction of labor with prostaglandin E_2 administered orally. *South Med J* 69:905-7, 1976.

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27. Sastry BVR, Olubadewo JO, Boehm FH: Effects of nicotine and cocaine on the release of acetylcholine

from isolated human placental villi. *Arch Int Pharmacodyn* 229:23-36, 1977.

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oxytocin and oral prostaglandin E_2. *J Tenn Med Assoc* 72:890-2, 1979.

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53. Boehm FH, Estes W: Genital herpes simplex during pregnancy. *Perinatology/Neonatology* 6:21-27, 1982.

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65. Boehm FH: Management of the unanticipated neural tube defect inlate pregnancy. *Clin Obstet Gynecol* 27:78-83, 1984.

66. Pittaway DE, Daniell J, Maxson W, Boehm FH: Reconstruction of the cervical canal after complete postconization obstruction: A case report. *J Reprod Med* 29:339-40, 1984.

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68. Boehm FH, Fields LM: Second-generation EFM is waiting in the wings. *Contemp Ob/Gyn* 23:179-88, 1984.

69. Meyer RM, Boehm FH: Oral intake during labor. *JAMA* 252:3181, 1984.

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71. Diamond MP, Shah DM, Hester RA, Vaughn WK, Cotton RB, Boehm FH: Complication of insulin-dependent diabetic pregnancies by pre eclampsia and/or chronic hypertension: Analysis of outcome. *Am J Perinat* 2:263-7, 1985.

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86. Lombardi SL, Boehm FH: Prophylactic cesarean section for a suspected macrosomic infant. *Collected Letters of the International Correspondence Society of Obstetricians and Gynecologists* 29:2-3, 1988.

87. Roussis P, Boehm FH: Intrapartum management of twin gestation in vertex-nonvertex presentation. *Collected Letters of the International Correspondence Society of Obstetricians and Gynecologists* 30:7-9, 1989.

88. Shah DM, Brown JE, Salyer SL, Fleischer AC, Boehm FH: A modified scheme for biophysical profile scoring. *Am J Obstet Gynecol* 160:586-91, 1989.

89. Fields LM, Boehm FH: Changing issues in FHR monitoring. *Contemporary OB GYN.* April 15, 1989, Special Issue: OB-GYN and the Law.

90. Lombardi SJ, Boehm FH: Vaginal birth after cesarean section: What Work-up? What Constraints?

Collected Letters of the International Correspondence Society of obstetricians and Gynecologists 30(4):2-93 1989.

91. Entman SS, Kambam JR, Boehm FH: Effect of maternal heme degradation on fetal carboxy-hemoglobin concentration in pregnancy-induced hypertension. *Am J Obstet Gynecol* 160:1394, 1989.

92. James AE, Fleischer AC, James JC, James E, Boehm FH, Bundy A: The concepts of wrongful birth and wrongful life and their relation to medical imaging. *Health Matrix The Quarterly Journal of Health Services Management* 7(1):54-7, 1989.

93. Shah DM, Boehm FH: Fetal blood gas analysis from cordocentesis for abnormal fetal heart rate patterns. *Am J Obstet Gynecol* 161(2):374-376, 1989.

94. Jeanty P, Johns R, Boehm FH: Uterine Ring and Fetal Demise. *J Ultrasound Med* 8:635-8, 1989.

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96. Nakajo S, Sugiura M, Snajdar RM, Boehm FH, Inagami T: Solubilization and identification of human placental endothelin receptor. *Biochemical & Biophysical Research Communications* 164(1):205-211, 1989.

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98. James Jr. AE, Fleischer AC, James III AE, Boehm FH, Bundy A, James JC, Sanders RC: Wrongful life

and wrongful birth: Implications for diagnostic sonography. *J Ultrasound Med* 8:597-601, 1989.

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100. Rosemond RL, Lombardi SJ, Boehm FH: Ferning of amniotic fluid contaminated with blood. *Obstet Gynecol* 75:338, 1990.

101. Shah DM, Roussis P, Ulm J, Jeanty P, Boehm FH: Cordocentesis for rapid karyotyping. *Am J Obstet Gynecol* 162:1548-50, 1990.

102. Boehm FH: What is the Upper Limit of Gestation for Which a Cerclage Can Be Placed? *Collected Letters of the International Correspondance Society of Obstetricians and Gynecologists* 31(3)4-5, 1190.

103. Silverberg K, Boehm FH: Haemophilus influenzae amnionitis with intact membranes. *Am J Perinatol* 7:270-1, 1990.

104. Zaner RM, Boehm FH, Hill GA: Selective termination in multiple pregnancies: Ethical considerations. *Fertil Steril* 54(2):203-5, 1990.

105. Roussis P, Rosemond RL, Glass C, Boehm FH: Preterm premature rupture of membranes: Detection of infection. *Am J Obstet Gynecol* 165(4):1099-1104, 1991.

106. Boehm FH, Lombardi SL, Rosemond RL: Immediate cerclage in the delivery room following delivery of one nonviable twin: A report of three cases. *J Reprod Med* 37(12):986-988, 1992.

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108. Boehm FH, Salyer SL, Dev VG, Reed GW. Chorionic villus sampling: Quality Control – A continuous improvement model. *Am J Obstet Gynecol* 168 (6, pt 1):1766-1777, 1993.

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110. Devoe L, Boehm F, Paul R, Frigoletto F, Goldenberg R, Rayburn W, Smith C. Clinical experience with the Hewlett-Packard M-1350A Fetal Monitor: Correlation of Doppler-detected fetal body movements with fetal heart rate parameters and perinatal outcome. *Am J Obstet Gynecol* 170:650-655, 1994.

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114. Boehm FH, Lombardi SJ. Reverse end diastolic flow velocity: Reassuring biophysical profile and acute fetal demise. *Maternal-Fetal Med.* 3:(2), 91-93, 1994.

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BOOK CHAPTERS:

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2. Fleischer AC, Boehm FH, James AE Jr: Sonographic evaluation of ectopic pregnancy. In Sanders R, James AE Jr (Eds): *Principles and Practices of Ultrasonography in Obstetrics and Gynecology,* Vol. 2, New York, Appleton-Century-Crofts, 1980.

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4. Fleischer AC, Boehm FH, James AE Jr: Sonographic evaluation of pelvic masses and maternal disorders occurring during pregnancy. In Sanders R, James AE Jr (Eds): *Principls and Practice of Ultrasonography in Obstetrics and Gynecology*, Vol. 2, New York, Appelton-Century-Crofts, 1980.

5. Boehm FH: Fetal abnormalities, hydramnios and oligohydramnios. In *Manual of Clinical Problems in Obstetrics and Gvnecologv With Annotated Key References*, Boston, Little, Brown & Co, 1981.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

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EXHIBIT 24

[LOGO]

ACOG *Statement of Policy*

As issued by the ACOG Executive Board

STATEMENT ON INTACT DILATATION AND EXTRACTION

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

The American College of Obstetricians and Gynecologists (ACOG) believes the intent of such legislative proposals is to prohibit a procedure referred to as "Intact Dilatation and Extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilatation of the cervix, usually over a sequence of days;
2. instrumental conversion of the fetus to a footling breech;
3. breech extraction of the body excepting the head; and

4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X.

Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the only option to save the life or preserve the health of the woman. An

intact D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American woman. The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.

Approved by the Executive Board

January 12, 1997

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 25

[LOGO] Vanderbilt University Medical Center

[Address Omitted In Printing]

Dear Dr. Levine:

I understand that the Reference Committee is considering the AMA Board's support of HR-1122 concerning the banning of partial birth abortion. Because of this, I would like to have my opinion and, therefore, this letter put into the record.

I am a Professor of Obstetrics and Gynecology at Vanderbilt Medical Center in Nashville. I have been in the practice of obstetrics and gynecology since 1970. I am Director of Obstetrics and the Maternal Fetal Medicine Division at Vanderbilt Medical Center and have held this position since 1980.

I believe that some pertinent information on my views on the subject of abortion is important. I was trained in obstetrics and gynecology before Roe vs Wade was passed in 1973. I observed during this time that because abortion was illegal in this country, many young women were tragically injured or died in the process of obtaining an illegal abortion. Watching helplessly as young women died despite aggressive surgical and medical treatment to prevent death was an experience that I will never forget and has certainly influenced me to this day. It was then and there that I became a strong advocate of choice. Since

1973 maternal mortality in this country has dropped significantly as a result of women throughout this country being able to obtain a legal and safe abortion.

Our group here at Vanderbilt has been offering abortions for significant fetal anomalies as well as maternal illness for the past twenty-five years and because of this, I have not only had considerable experience on the subject of abortion as well as the technique, but I have had an opportunity to reflect on how we as a medical profession approach the process of abortion.

I wish to make it clear that I unequivocally support a ban on the performance of partial birth abortions. The subject of partial birth abortions has become quite controversial as well as confusing. Adding the term "late-term abortion" to the subject has deepened the confusion.

The two mean different things. It has only been recently (January 1997) that the American College of Obstetricians and Gynecologists, a group that I belong to and have worked for in the past, has defined the procedure of partial birth abortion. Prior to this time, there was no definition of this procedure nor any description or research in our literature. A late-term abortion is an abortion performed after the time when a fetus is considered able to have a reasonable chance of survival outside its mother's uterus. There is considerable unanimity of opinion on when this gestational age limit has been reached, and that currently is 24 weeks from a woman's last menstrual period.

Partial birth abortion has never been performed at our institution in the twenty-five years that I have been here, nor to my knowledge has anyone else in the state of

Tennessee performed such a procedure. I have been in contact with all directors of obstetrics throughout the state, as well as virtually all practitioners in the Middle Tennessee area, and I can state with close to 100% certainty that such a procedure has never been performed in our state.

There is never a medical need to perform the procedure as defined by the American College of Obstetricians and Gynecologists as a partial birth abortion. There are potent prostaglandin substances, as well as other mechanisms including oxytocin, as well as the process of dilatation and extraction (D&E), that are proven efficient, relatively rapid, and safe. Most physicians in this country do not offer abortions after viability has been reached (approximately 24 weeks). Delivery after this time, which is needed in order to protect the life and health of the mother, is performed by labor induction or caesarean section with the intent to deliver a live baby. Therefore, there is never a need nor a reason morally, ethically, or legally to perform an abortion in a woman who has reached a 24 week gestational period. Prior to this time, other mechanisms can suffice, and, therefore, it is my strong opinion that there is no indication for this procedure.

In addition, I believe that this particular abortion procedure, which is only performed by a few physicians throughout this country, is morally and ethically difficult to support. While all abortions are in some individuals mind morally and ethically difficult to support, I believe this particular procedure is offensive to even those of us who consider ourselves Pro-Choice. There are many in this country who believe that the Pro-Choice Movement

is abandoning the moral framework and guidance that is needed in this country when considering the process of abortions. This offensive procedure, which results in delivery of a live fetus up to the neck and then literally sucking out its brain causing the fetus to become rigid and then finally limp, is not only emotionally difficult for the health care providers to perform, but difficult to observe by those helping those performing the abortion, as well as the patient herself and her family. In view of the fact that there is no medial need and that there are safe alternatives, it is my opinion that such a procedure should be banned so as to comfort the general public in this country that abortions are not in the hands of callous extremists.

The language of the bill before you does not include the accepted and relatively safe abortion process called "dilatation and extraction (D&E)". As stated in the bill, "vaginally delivering a living fetus before killing the fetus means deliberately and intentionally delivering into the vagina a living fetus or a substantial portion thereof for the purpose of performing a process the physician knows will kill the fetus and then kills the fetus" clearly does not mean the same as a D&E. The fact that the living fetus has to be totally brought through the vagina or a substantial portion thereof, would preclude any confusion with D&E, which does not bring the entire fetus or a substantial portion into the vagina for the purpose of killing it.

Because of all this, I believe the AMA has performed an important duty in this country by sticking its neck out on a very controversial subject. With 70% of Americans believing that abortion should remain legal, safe, and

rare, I believe that they also wish to have certain moral and ethical guidelines for which this process should be undertaken. Clearly partial birth abortion is an affront to the average American who generally supports the right of choice. Because of this, I believe the AMA is making a strong statement of support of those individuals, including the many physicians who are also in opposition to this procedure.

The banning of partial birth abortion will not change any abortion number and will not infringe on those who do abortions or their ability to perform them in a safe manner. No slippery slope will be stumbled upon, no women will die or lose their health because a partial birth abortion is not available to them.

It is also important to remember that any physician who wishes to cause fetal demise by an intracardiac injection prior to the procedure described by ACOG as partial birth abortion would, in fact, not be violating the law banning its performance because the definition states that "the physician delivers a living fetus before killing the fetus in the vagina." If a physician causes fetal death prior to the procedure itself, that physician would not then be guilty under this definition. Therefore, with this very large loophole, it is clear to me and others that the banning of partial birth abortion is not a medical issue but more a political and moral one.

The AMA's moral leadership in this area is needed, and many physicians who are Pro-Choice will be pleased to

support the AMA's final acceptance on the banning of partial birth abortion.

Sincerely,

/s/ Frank Henry Boehm
Frank Henry Boehm, M.D.
Professor of Ob-Gyn
Director of Obstetrics
Vanderbilt Medical Center
Nashville, Tennessee

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 26

**IN THE CIRCUIT COURT OF
DAVIDSON COUNTY, TENNESSEE
AT NASHVILLE**

PLANNED PARENTHOOD ASSOCIATION OF NASHVILLE, INC., MEMPHIS PLANNED PARENTHOOD, INC., PETER CARTWRIGHT, M.D., FRANK BOEHM, M.D., and WASHINGTON HILL, M.D.	)	No. 92C-1672
Plaintiffs	)	
v.	)	
NED R. MCWHERTER, Governor of the State of Tennessee, in his official capacity, *et al.*	)	
Defendants.	)	

AFFIDAVIT OF FRANK BOEHM, M.D.

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

I, FRANK BOEHM, M.D., having been duly sworn, do state as follows:

1. My name is Frank Boehm, M.D., and I have personal knowledge of the facts contained in this affidavit. I submit this affidavit in support of plaintiffs' motion for a temporary restraining order or preliminary injunction.

2. I am a physician licensed to practice medicine in the State of Tennessee. I am board certified in obstetrics and gynecology and in maternal fetal medicine, and have practiced in those areas since 1966. I am a fellow of the American College of Obstetricians and Gynecologists (ACOG). I am currently a professor of Obstetrics and Gynecology at the Vanderbilt University School of Medicine. In addition to my teaching duties, I have a private practice treating high-risk obstetrics patients and consulting in problem pregnancies. During the course of my practice, I perform and supervise abortions and advise women seeking abortions.

3. I have reviewed the Tennessee criminal abortion law being challenged in this case. It is my opinion based on my experience and professional expertise that the statute will cause health risks and unnecessary mental anguish for women seeking abortions in this state, will make it more onerous and expensive for women to obtain abortions, and will prevent many women from obtaining safe and legal abortions. If this statute goes into effect, I believe that the number of illegal and dangerous "back alley" abortions in Tennessee will increase. In addition, the statute is confusing and badly drafted, and does not give me or other physicians advising pregnant women fair warning of how to avoid criminal penalties.

HOSPITALIZATION REQUIREMENT.

4. The requirement that abortions after the first three months of pregnancy be performed in a hospital is confusing and unclear to me as a physician. The term "three months" of pregnancy is not defined in the statute. Modern obstetrical practice generally measures the length of pregnancy from the first day of the woman's last menstrual period (LMP), although actual conception or fertilization occurs two weeks after this point. As a physician, when I say that a woman is twelve weeks pregnant, I mean that twelve weeks have elapsed from the beginning of the woman's last menstrual period (LMP). Generally, however, only ten weeks have elapsed since conception occurred. I have no idea whether the phrase "first three months of pregnancy" in the statute relies on general obstetrical practice to measure the length of pregnancy from the date of the last menstrual period, or whether it measures the pregnancy from the date of conception. In addition, it is not clear whether "the first three months" refers to calendar months (approximately twelve weeks) or whether it means the "first trimester" of pregnancy, which is approximately fourteen weeks LMP.

"INFORMED CONSENT" REQUIREMENTS.

5. The requirement that physicians, rather than qualified counselors, provide the informed consent information required by the statute is unnecessary and will merely make abortions more expensive and difficult to obtain.

6. Some of the "facts" that the statute directs physicians to tell women seeking abortions are false and misleading. In addition, the provisions are confusing and contradictory and do not give me or any physician clear notice of what we must tell women seeking abortions.

7. The requirement that physicians tell women that abortion in a considerable number of cases is a major surgical procedure is obviously wrong. Abortion is almost never a major surgical procedure.

8. The requirement that physicians tell women that numerous public and private agencies are available to assist her during pregnancy and after the birth of her child, and give women a list of such agencies on request is inaccurate, misleading, and unclear. Although it is my practice to assist women considering abortion by telling them about the agencies and services of which I am aware and by fully discussing with them their options. I do not believe that "numerous" agencies and services exist, especially with regard to assisting women after birth if they choose not to give their child up for adoption. I have never attempted to formulate a list of such agencies and services and believe that it would be impossible to do so within the terms of the statute.

9. The requirements that physicians tell women of the "risks and benefits" of abortion or continued pregnancy and of the "particular risks" of her situation are confusing and redundant. Although I always discuss with a woman seeking an abortion the risks of her situation, I have no idea of how to address the "benefits" of abortion or continued pregnancy. Moreover, to my mind the separate requirements that physicians discuss the "risks and

benefits" and the "particular risks" mean the same thing. I am unsure, from reading these provisions, of what the statute requires me to tell a woman in order to avoid criminal penalties.

10. I believe that in many cases among my patients the requirement that I go through these "facts" with the woman seeking an abortion is unnecessary, inconsistent with good medical practice, and punitive. Often, my patients are seeking abortions because their fetus is seriously malformed or for other medical reasons. In such situations it is cruel and inconceivable that I am required to tell a woman that there are numerous agencies available to assist her if she chooses to keep her child or that I am required to describe the numerous benefits of continued pregnancy, as in many instances a continued pregnancy is not even an option to them.

WAITING PERIOD.

11. The three day waiting period mandated by the statute provides no benefit to a woman seeking an abortion, and will only make obtaining abortions more difficult and expensive, especially for poor women who may have traveled to Nashville from rural areas in order to obtain an abortion. In addition, in many cases this waiting period requirement will prevent women from obtaining abortions at all. For these women, waiting the three days prescribed by the statute will take them past the term of pregnancy (fourteen weeks LMP) during which Planned Parenthood will perform an abortion. Abortions after this period are unavailable in Nashville for women with healthy fetuses.

12. This waiting period requirement will be particularly difficult and punitive to women among my patients who are seeking abortions because of malformed fetuses. Making such women wait to obtain an abortion is unnecessary, inconsistent with good medical practice, and cruel.

PARENTAL NOTIFICATION.

13. In my opinion, the requirement that both parents of a minor be notified of her decision to seek an abortion, and the lack of provision for judicial bypass of this notice, will lead to an increase in illegal and dangerous "back alley" abortions. Those minors who are unable to notify their parents of their pregnancy, and who are unable to get a legal abortion without such notification, may well seek abortions through illegal channels. I saw the horrible results of such illegal abortions during my practice before safe and legal abortions were readily available, and I believe that a resurgence of these cases will occur if this statute is not enjoined.

Further affiant sayeth not.

/s/ Frank Boehm
Frank Boehm, M.D.

Sworn to and subscribed before me on this the 23rd day of July, 1992.

/s/ Patricia A. Adam
Notary Public

My commission expires:

September 24, 1994

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent by regular U.S. Mail, postage prepaid to Mike Catalano, Counsel for Ned R. McWherter, Deputy Attorney General, 450 James Robertson Parkway, Nashville, Tennessee 37219 and Victor Johnson, Assistant Attorney General, Metropolitan Courthouse, Second Floor, Nashville, Tennessee 37201 this 23 day of July, 1992.

/s/ Irwin Venick
IRWIN VENICK

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 27

VIDEOTAPED DEPOSITION OF
FRANK HENRY BOEHM, M.D.

Friday, January 23, 1998

[p. 2] The videotaped deposition of FRANK HENRY BOEHM, M.D., was taken by counsel for the Defendant at the offices of Dr. Boehm, Vanderbilt University Hospital, B-100 Medical Center North, Nashville, Tennessee, on Friday, January 23, 1998, beginning at approximately 11:30 a.m., for all purposes allowed under the Federal Rules of Civil Procedure.

It is agreed that Carol A. Nichols, Registered Diplomate Reporter, Certified Shorthand Reporter, and Notary Public for the State of Tennessee at Large, may swear the witness, take the deposition, and afterwards reduce same to typewritten form, and that the reading and signing of the completed deposition by the witness is waived.

All formalities as to caption, certificate, transmission, filing, et cetera, are waived. All objections are waived, unless stated during the deposition.

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[p. 3] EXHIBITS

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*Retained by Counsel

[p. 4] FRANK HENRY BOEHM, M.D.,

having been duly sworn, was examined and testified as follows:

(Exhibit 23 marked.)
(Exhibit A marked.)

MR. SMITH: Just for one housekeeping matter, the Notice of Deposition for this deposition has been marked as Exhibit A. I would offer it to be part of the record of the deposition. Do you have any objection, Mr. Heller?

MR. HELLER: No.

MR. SMITH: And would also state for the record that the parties have stipulated that all objections are waived unless made during the deposition; is that agreeable?

MR. HELLER: Yes.

EXAMINATION

BY MR. SMITH:

Q. Would you state your name, please?

A. Frank Henry Boehm.

Q. And what do you do for a living?

A. I'm an obstetrician/gynecologist at Vanderbilt Medical Center.

[p. 5] Q. Okay. And as far as your medical specialty, what is your medical specialty?

A. Well, it's obstetrics and gynecology with a subspecialty of maternal-fetal medicine.

Q. And are you certified by any American boards of medical specialties?

A. Yes. I am certified by the American Board of Obstetrics and Gynecology in both obstetrics and gynecology and maternal-fetal medicine.

Q. And you're a licensed physician by the state of Tennessee; is that correct?

A. Yes.

Q. And, Dr. Boehm, I'm showing you your curriculum vitae that's been marked as Exhibit 23. Is your curriculum vitae, Exhibit 23, is that accurate?

A. Yes, it is.

Q. And it's accurate concerning your education [sic] and your professional credentials?

A. It is.

Q. Now your curriculum vitae reflects that you completed your medical education and your residency training prior to the United States Supreme Court decision in Roe v. Wade; is that correct?

A. Yes.

Q. And it would then be an accurate statement [p. 6] necessarily that your basic educational training in obstetrics was completed when abortions were illegal in this country, correct?

A. That's correct.

Q. And prior to the legalization of abortions, did you treat women who had complications arising out of illegal abortions?

A. Yes.

Q. And can you generally tell us what your experience was in that regard?

A. Well, when I started obstetrics, I was a young kid who really didn't have much of an opinion about the matter of abortion. It was not table conversation when I grew up or even when I went to school. But becoming a

resident in obstetrics and gynecology in New Haven, Connecticut, in the middle '60s, it brought me face to face with the problems that women throughout this country were facing when they were dealing with an unwanted pregnancy. Virtually every night a woman was admitted to the Yale-New Haven Hospital emergency room with complications of an illegal abortion. And so therefore the experience that myself and my fellow residents had in dealing with this condition and problem was considerable. It convinced me that we had a real [p. 7] problem in this country where women were going to have illegal abortions that were quite unsafe and especially many of the poor women. The more wealthy seemed to go out of the country or to find other techniques. But still it was both rich and poor alike that we admitted. Many of the women were admitted severely ill and required long hospitalizations often with loss of fertility. Some we did hysterectomies to save their life. And on several occasions I was present and pronounced dead women who died of complications. Within a few years of this experience, I became a strong advocate for choice and for a change in the law that we had existing in this country.

Q. And to understand your personal views concerning the subject of abortions, do you have personal views?

A. Sure. I have not wavered in my advocacy of the pro-choice movement. I also consider myself pro-life though. I think most physicians don't like to have to use those terms "pro-choice" and "pro-life". I do like to think of myself as a promoter of life. On the other hand, I believe choice as defined by Roe v. Wade is reasonable. I believe we have laws in this country that protect a woman's choice.

[p. 8] So I have always been an advocate of pro-choice, but I have also been an advocate of limitations, assuming they're not unduly burdensome to the woman, is also appropriate and demonstrates responsible behavior by society and more specifically by physicians and health care providers performing abortions.

Q. Okay. And since Roe v. Wade and the legalization of abortions in this country, have you performed abortions, yourself?

A. Yes.

Q. And can you give us – attorneys always throw out – want to know the numbers. Can you give us an approximation of the number of abortions you have performed in the last 25 years?

A. It's certainly less than 1,000, but I couldn't give you an exact number.

Q. Okay. As far as any range, are you able to give any estimate of a range?

A. I really can't.

Q. You think you have performed over at least 100 abortions?

A. Oh, yes. It's more than 100, and if we go back to the early 1970's through to today, it's more than 100 but certainly less than 1,000. The abortions [p. 9] that I do are generally second trimester, congenital anomaly abortions where we have serious malformations of the fetus. I think that's the gravest percentage of abortions that I do and have done in the last 25 years.

Q. Do you consider yourself knowledgeable on the subject of abortion?

A. Yes.

Q. Do you consider yourself a medical expert on abortion procedures?

A. Yes.

Q. And the abortions that you've performed in your or – strike that. The abortions that you've performed in your medical career, have you done those strictly in a hospital setting or in a hospital and clinic setting?

A. Well, the first trimester abortions that I have done have been in a clinic setting or outside the hospital, although maybe attached to the hospital since that's what we have here at Vanderbilt. All second trimester abortions have been done in a hospital.

Q. And you're familiar that the American Medical Association did a study last year on abortions?

A. Yes.

Q. And I'm showing you what's been marked as Exhibit 7, which is the Exhibit 7 for the trial, which [p. 10] is a portion of the American Medical Association report. And if you would, turn to the page, page number 6 at the top of the page of Exhibit 7. Down at the bottom it says, "Procedures used to induce abortion." Do you see that?

A. Yes, I have it.

Q. Okay. And as far as the procedures starting on that page going through the next page on first trimester procedures and on the following page, it's page number 8

at the top, describes mid trimester and third trimester procedures to induce abortions and continuing on the following page number 9, the abortion procedures that are described on the pages just indicated, are you familiar with those procedures?

A. Yes.

Q. And do you take any or have any disagreement with the American Medical Association's paper, Exhibit 7, as far as their description of the procedures?

A. No.

Q. Now when is the last time you performed an abortion?

A. We're probably talking about just weeks ago. We have patients who are admitted to our labor and delivery suite for this. And if I'm the attending [p. 11] on call, almost every time that I take a week on call, which is every five weeks, there are patients who are admitted under my name for prostaglandin termination of second trimester abortions. So I would be the doctor of record as having participated and performed the abortion.

Q. And as far as the approximate number of abortions you may have performed in the last year, do you have any idea what that might be?

A. Certainly more than a dozen.

Q. Do you do what could be described as elective abortions?

A. No.

Q. And what do you understand an elective abortion to be?

A. Well, an elective abortion, for purposes of this definition, would be someone who just doesn't want to be pregnant. There are no risk factors, no maternal health problems, a pregnancy that is not wanted at that particular time in a woman's life.

Q. Okay. But if a woman comes to you as a patient – and I assume you've had women come to you as patients who wanted to have an elective abortion; that's happened, correct?.

A. Oh, yes. If a patient that is one of my [p. 12] private patients comes in and wants an elective abortion, which happens very rarely, but if it were to happen and has happened in the past, I will recommend that she go to one of our two abortion clinics here in Nashville for a first trimester abortion. If that's unacceptable to her and she asks me to do it at Vanderbilt as an outpatient in the first trimester, I will do that.

Q. Now as far as just your source of your knowledge, experience, background on abortions, do you discuss abortions with other physicians who perform them?

A. Sure.

Q. Okay. Discuss abortion techniques?

A. Yes.

Q. Okay. Share professional knowledge as far as their experiences in doing abortions?

A. Yes.

Q. And has this been something, a practice of yours over your entire professional career?

A. Yes.

Q. Okay. And as far as – just to have an idea as to who might be the numbers of physicians that you have that perform abortions that you have such conversations with, any idea as to –

[p. 13] A. How many?

Q. Yeah.

A. Dozens, dozens. Remember, I teach at Vanderbilt, so I've talked to medical students and nurses and doctors and it's in the hundreds if you include medical students and nurses, residents, colleagues around the country. Let me change that number from dozens to hundreds.

Q. Okay. And you anticipated my next question is do you teach abortion techniques here at Vanderbilt?

A. Yes.

Q. And do you have any teaching or supervisory responsibilities for residency programs?

A. Yes.

Q. And those would be residency programs in obstetrics and gynecology?

A. That's correct.

Q. And do you instruct on abortion in the residency programs also?

A. Yes.

Q. As far as your experiences, what would be the approximate latest gestation that you've ever performed an abortion?

A. We would stop once a patient reaches 23 weeks.

[p. 14] Q. And you stop why?

A. Because at 24 weeks there is a reasonable chance of survival which is about 50 percent at this particular point in time.

Q. You're referring to the fetus?

A. The fetus, and because 23 weeks includes 23 weeks and 6 days, we give ourselves a week of buffer so to speak so we don't make any errors or minimize the error as much as possible. And so we do not do abortions after 22 weeks and 6 days. That's from the last menstrual period.

Q. Okay. And your explanation would assume that you are familiar just with the statistical data on viability of fetuses?

A. I am aware of statistical data on survivability. Viability is defined by many states differently and by individuals differently. My definition is accepted by many although it may not be the only definition, and that is the time in which a fetus has a reasonable chance of survival outside its mother's uterus.

Q. You would consider that to be 23 weeks?

A. Well, I would consider that to be 24 weeks.

Q. And 23 weeks would be -

A. But at 23 weeks there's approximately a 10 to 15 [p. 15] percent chance of survival with a 90-plus percent severe morbidity. So I don't really like to consider 23 weeks, but when you are Director of Obstetrics and you have to come up with rules and regulations, which is what I have to do, we have set as an outer limit 23 weeks so that we didn't get into the problem of being so close to 24 weeks that we made errors. So I still consider viability to be 24 weeks.The reason we use up to 23 weeks at Vanderbilt is a procedural, technical reason rather than an actual definitional interpretation of viability.

Q. As far as the type of abortion procedures that you've performed yourself, could you tell us what type of abortion procedures you've performed in your experience?

A. Well, I've performed the D & C and the suction D & C in the first trimester. I've performed some D and E's earlier in my career although I haven't, as I think I've indicated – not performed a D & E myself as a sole provider in ten years at least. I performed saline abortions years ago, installation of prostaglandin, intraamniotic, and I have participated in hysterotomies. And I have participated in more recently the use of prostaglandin drugs to initiate labor and delivery.

[p. 16] Q. Are you aware of an abortion procedure known as the dilation or dilatation and extraction procedure?

A. The D & X procedure?

Q. Yes.

A. Or the D & E procedure?

Q. D & X.

A. D & X. That's the intact D & E or D & X. Yes, I'm familiar with it inasmuch as I've read about it.

Q. Okay. Have you actually performed such a procedure?

A. No.

Q. Have you ever been present when any other physician has performed such a procedure?

A. No.

Q. Okay. And if you would, turn to Exhibit 8, page number 8 at the top. In the last paragraph there of page 8, Exhibit 7, the AMA report describes the intact D & X procedure. Do you see that?

A. Yes.

Q. Okay. And the second-to-the-last sentence states, "This procedure may minimize trauma to the woman's uterus, cervix, and other vital organs." Do you see that?

[p. 17] A. Yes.

Q. Do you know if that has ever been proven medically?

A. No. I think the sentence indicates that it may, but it also indicates that it may not. There's never been to my knowledge any studies that have compared the trauma to a woman's uterus, cervix, or other vital organs with either technique.

Q. Do you view that sentence as being in the context of theory?

A. Yes.

Q. And the next sentence says that an intact D & X may be preferred by some physicians continuing through the rest of the sentence. Do you see that?

A. Yes.

Q. And again as far as that being a statement of fact, do you have any understanding as to whether or not some physicians may prefer the intact D & X, if you know?

A. Well, I think it's the same here. It may would also include to may not. I think it bridges on the realm of possibilities that there are instances where a fetus has been diagnosed with hydrocephaly, as the sentence concludes, or other abnormalities incompatible with life outside the womb. So I don't [p. 18] have any reason to disagree with it, but I don't know of any studies that would indicate the numbers of doctors that fall into the category that may versus those who may not.

Q. Okay. Now as far as the significance to you as a physician applying medical standards, is there a distinction between something which has been medically proven and something which is medical theory?

A. Oh, huge, huge difference.

Q. And can you explain what the distinction would be as far as medical standard?

A. Sure. Medical standard comes from many years of study of a certain procedure, for example, that has

been compared and described in the literature and studied as to its safety compared to other techniques. For example, a procedure would be performed on 4- or 500 patients, half of which would have one procedure, the other half would have the other procedure, then outcome data would be looked at, statistical significance would be applied, and conclusions would be reached. The scientist or the investigator would then send that to a journal. That would be reviewed by statisticians, by other doctors knowledgeable in that field. The study would then be deemed acceptable or [p. 19] unacceptable and it would be published. And it's a body of this publication of work of a procedure or a technique or a theory that eventually is proven or disproven based on that body of work and the scientific studies that have undergone to try to understand whether that technique is in fact safer or better or shorter or cheaper or whatever the intention of the study is.

That's how standard of care comes. A theory is just a theory and has never been proven by anyone to be fact.

Q. Okay. Now the intact D & X procedure and particularly the second-to-the-last sentence as described in the AMA report on page 8, Exhibit 7, has that ever been medically proven in the method that you've described as far as the procedure would minimize trauma to the woman's uterus, cervix, and other vital organs?

A. No.

Q. Are you aware of any ongoing studies in that regard?

A. No.

Q. The intact D & X as described in the AMA report refers to the American College of Obstetricians and Gynecologists, correct?

[p. 20] A. Yes.

Q. And are you familiar with the American College of Obstetricians and Gynecologists' statement of policy?

A. Yes.

Q. And I'm showing you what's been marked as Exhibit 24. Is that the American College of Obstetricians and Gynecologists' statement of policy on intact D & X procedures?

A. It is.

Q. And at least Exhibit 24, the policy reflects that it was approved by the executive board in January of '97. And prior to the American College of Obstetricians and Gynecologists approving the statement of policy, are you aware of whether the intact dilatation and extraction procedure had ever been described in any medical text?

A. It had not been.

Q. Had it appeared the intact D & X procedure been described in any peer review literature prior to the ACOG statement of policy?

A. It had not, and that's why the American College of Obstetricians and Gynecologists put out a statement of policy, because it had been discussed in the press and it had no definition by our organization [p. 21] and our professional group anywhere so that it needed some definition, and this is what ACOG came up with.

Q. And what is your affiliation, if any, with ACOG?

A. I'm a member.

Q. And have you ever in the past been involved in developing any ACOG policy statements?

A. I have.

Q. And I take it those would be described in your curriculum vitae?

A. What would be in my vitae is the years that I spent on various committees where that was – where writing policies and assisting in consulting on policies when that work was done.

Q. And the ACOG policy statement, Exhibit 24, if you would turn to the second page, do you see the sentence that says, "An intact D & X however may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman. And only the doctor in consultation with the patient, based upon the woman's particular circumstances, can make this decision." Do you see that?

A. Yes.

Q. Do you agree or disagree with that?

[p. 22] A. Well, I disagree.

Q. Why?

A. Based on the fact that there's no data to support either one. Again, ACOG says it may be the best. It doesn't say that it is or that there's any data to support that. It is still theory in the same context as was discussed earlier by the AMA's wording.

Q. Now the executive board of the ACOG that approved the policy statement, do you know any of the members of the executive board?

A. Yes.

Q. And have you communicated with any of those board members concerning this ACOG statement of policy?

A. Yes.

Q. And who would that be?

A. One in particular, Dr. Ralph Hale, the Executive Director.

Q. Of the executive board?

A. Well, he's Executive Director of the American College of Ob/Gyn. I don't know if he served specifically on this particular executive board. I would imagine he did, but I don't know that for sure.

Q. Have you made your views known to him concerning your disagreement with the aspects of the second page of the policy statement?

[p. 23] A. Yes.

MR. HELLER: Objection just as to relevance, whether he made his views known to ACOG.

BY MR. SMITH:

Q. And what's your – did you receive any response from him concerning whether or not the sentence previously read as far as the intact D & X being the most appropriate procedure, as to whether or not that was theory or proven?

A. His response to me –

MR. HELLER: Objection, hearsay.

THE WITNESS: His response to me did not deal with that particular question. It dealt with other aspects but not with that one.

BY MR. SMITH:

Q. Do you have an opinion as to the relative safety of the intact D & X procedure versus other abortion procedures as it relates to a woman's health?

A. I don't have a real opinion about it other than that I don't know. No studies have been done to show outcome, one compared to another.

Q. Okay. In your medical opinion are there any situations in which an intact D & X abortion procedure would be a safer abortion procedure for a woman than another abortion procedure?

[p. 24] A. No.

Q. I'm trying to remember my question. I can't recall if I asked you if you have an opinion or – let me back up. Do you have a belief, one way or another, whether an intact D & X procedure would be safer in any medical situation for an abortion than any other abortion procedure?

A. I have an opinion.

Q. Okay. What is your opinion?

A. I don't have any evidence that it is safer, so my opinion is that without data to support it, I don't know.

My answer has to do basically with trying to be – trying to bring up theory and have that result in fact. And without facts I couldn't possibly answer that question. I believe there are very safe alternatives, but I know of no study that compares procedures with the D & X.

Q. Now I'm showing you Nebraska's partial birth abortion bill. It's Legislative Bill 23. Have you previously reviewed the bill?

A. Yes.

Q. Okay. And at least the bill in the form it appears – and I believe it's attached to the plaintiff's complaint – on page 4 starting at line 9, it has a definition of partial birth abortion. And [p. 25] you're aware that that was the definition of LB23 in Nebraska?

A. Yes.

Q. And that that – as described, partial birth abortions are banned in Nebraska by that particular legislation?

A. Yes.

Q. Do you – as a physician do you understand the definition of partial birth abortion as drafted by Nebraska's LB23?

A. I believe I do.

Q. Okay. And does Tennessee also have a partial birth abortion bill?

A. Yes.

Q. Okay. And would you agree that the definition of partial birth abortion in Tennessee is the same as

Nebraska's except Tennessee uses the word "fetus" rather than "unborn child"?

A. Yes.

Q. And Tennessee also bans partial birth abortion; correct?

A. Yes.

Q. Now in your opinion would the banning of the partial birth abortion as defined by LB23, would that create any adverse medical risk to the health of [p. 26] any woman seeking an abortion?

A. It would not.

Q. And why do you say that?

A. Because there are safe alternatives.

Q. And the alternatives would be what?

A. Well, the basic one would be induction of labor with chemical compounds such as prostaglandin.

Q. And that's typically done in a hospital; correct?

A. Yes.

Q. As far as are there safe alternatives that could be performed in a clinic setting?

A. D & E's can be done and are done in clinic settings, usually not beyond 18 weeks, but that could be done as a safe alternative in a clinic setting.

Q. Now the ban of partial birth abortions in Tennessee, does the Tennessee ban affect your ability to perform medically safe abortions?

A. No.

Q. To your knowledge does the Tennessee partial birth abortion ban affect the ability of any Tennessee physician to perform medically safe abortions?

A. No.

MR. HELLER: Objection. Foundation [p. 27] for his knowledge and relevance.

THE WITNESS: No.

BY MR. SMITH:

Q. Do you know of any Tennessee physician who performs or has performed a partial birth abortion as described by the Tennessee legislation?

MR. HELLER: Objection again as to relevance.

THE WITNESS: No.

BY MR. SMITH:

Q. Have you made any specific inquiries in that regard to find out if physicians performing abortions in Tennessee have performed partial birth abortions?

A. I have.

Q. And can you tell us what you have done as far as making inquiries in that regard?

A. I've called my colleagues all across the state from Memphis, including abortion providers here in Nashville, Directors of Obstetrics and individuals who are knowledgeable about what goes on in their community about concerning abortions in Knoxville, Chattanooga, and the Tri-City area of Kingsport, Bristol, and Johnson City.

Q. Okay. And your inquiries, do you believe [p. 28] they have allowed you to determine what is the state of practice, at least in the state of Tennessee, on partial birth abortions?

MR. HELLER: Objection. I don't think his field of expertise includes surveys of physicians in Tennessee.

BY MR. SMITH:

Q. Go ahead and answer the question.

A. I believe within the limitations mentioned that it does allow me to have a reasonably good handle without a doctor-by-doctor survey as to what is going on in the state of Tennessee as far as abortion techniques are concerned.

MR. HELLER: Again, I'm just going to object based on the relevance of what's going on in Tennessee.

MR. SMITH: And if I could state for relevance, the relevance to me is at least on the procedure, LB23 has the same partial birth abortion definition of ban as does Tennessee.

BY MR. SMITH:

Q. That being said, Doctor, are you aware of any physician in Tennessee, based on your inquiries, that has not been able to perform the abortion technique described in the partial birth abortion ban [p. 29] because of the ban?

A. No.

Q. Now do you also here at Vanderbilt teach medical ethics?

A. Yes.

Q. And can you give us a little overview as to what your involvement would be with the responsibilities for teaching medical ethics?

A. Well, I am Chairman of the Vanderbilt Medical Center's Ethics Committee and have been that for approximately six years so that I teach ethics and help with ethic policy in the hospital or review policy that may affect ethics. And I participate in a large number of different educational opportunities for our entire medical facility.

Q. And how long has that been the case as far as your teaching and your responsibilities for medical ethics?

A. Well, I've been interested in ethics for 15 years or so and have served on the committee but have only been chair of that committee for – I think this is my seventh year.

Q. Okay. And your interest would be the interest as far as teaching and from an academic interest?

[p. 30] A. I think medical ethics is an important part of medical education and needs to be taught to students and residents and others because it is part of what we do and how we do things.

Q. Now the ban on partial birth abortions as drafted by LB23 and a similar legislation in Tennessee, does that have any effect or relationship with the ethics of the medical profession?

A. I believe it does.

Q. And can you explain what the relationship and effect would be?

A. Sure. I believe that it is the responsibility of the medical profession, especially those of us who are responsible for teaching and carrying out certain procedures like abortion, that there needs to be certain guidelines, a certain framework that doctors work – doctors and nurses work within.

And I believe that those guidelines should be respectful of certain elements including the taking of a human life which is done through an abortion. And I think those of us who are interested in this subject are the ones that are responsible for speaking out when individuals in our community, medical community step over the line that we believe is made in [p. 31] differentiating what is morally and ethically acceptable and what is not.

And while I'm the first to admit that that depends on the individual and that there are many individuals who would say that any abortion is morally unacceptable, I believe those of us who believe ourselves to be supporters of women's rights to choose, that that choice does need some limitations, some boundaries. And many of them are boundaries that are defined by morality and ethics.

And so that is really where I came to the conclusion that this particular procedure, the partial birth abortion, stepped over that line. And because of that and the fact that it wasn't needed to begin with should be a place where we make a stand and say, This is unacceptable, and other things may be acceptable, but this is not acceptable.

Q. And as what you said relates to medical ethics as I understood it, the ethics would be doing an abortion procedure which is not medically necessary?

A. I think that would be characteristic of it. The field obviously gets somewhat confusing because the term "late term abortions" have also been part of this particular process. Again, "late term abortion" has no meaning in medicine. If it means post-viability, then [p. 32] I think abortions – again, to offer abortions after viability is one of those other steps across that line that makes it unethical and immoral.

And so when you put the two together, for many of us who are interested in this field, I believe that it represents a departure from what is morally and ethically acceptable by the medical profession and especially those of us who agree with pro-choice and who perform-abortions.

Q. Now the legislative ban on partial birth abortion as defined by LB23, would that ban mean that a woman seeking abortion would have to go an alternative procedure which would create a higher risk of harm to her uterus, cervix, or internal organs?

A. No.

Q. And why do you say that?

A. Well, for a variety of reasons. One is that we've been performing abortions for years on women safely with other techniques, and we don't have any data that would say that another technique such as partial birth abortion is any safer.

Q. Do you know what the medical term disseminated intravascular coagulopathy, what that means?

A. Sure.

[p. 33] Q. Did I pronounce it right?

A. Sure, you did a good job.

Q. Can you tell us what it is?

A. It is a condition where the patient's blood does not clot and throughout the body disseminated; intravascular meaning inside the vessels of veins and arteries, the blood doesn't clot. And that comes from a variety of medical factors that causes this – that condition.

Q. And would banning the partial birth abortion as defined by Nebraska's LB23, would that increase the woman's risk of disseminated intravascular coagulopathy?

A. No.

Q. And why not?

A. Well, first of all, the abortions don't result in DIC. That might make it easier for you. We use the term "DIC" for disseminated intravascular coagulation or coagulopathy. There are some conditions in obstetrics that lead to DIC, but the inability to do a partial birth abortion doesn't increase it one way or the other.

Q. Is there any correlation between DIC and abortion procedures?

A. There can be with significant hemorrhage or [p. 34] infection or amniotic fluid embolism or abruption.

Those are the – or dead fetuses. Those are probably the five most significant conditions related to DIC. But I do not believe that abortion techniques increase that incidence of any significance.

And certainly no one has ever looked at if DIC caused by the conventional techniques that we use for abortion is any higher or lower when compared with an equally manipulative procedure in the uterus, which is the partial birth abortion.

Q. Do you know what amniotic fluid embolus is?

A. Sure.

Q. And can you tell us what that is?

A. Well, it's an anaphylactic reaction. It's an allergic reaction when certain substances of the intrauterine contents are released into the maternal circulation. It's a very rare event, and it carries a very high mortality. And it can happen any time you are manipulating intrauterine cavity. So it can occur with a D & C, a D & E, cesarean section, labor and delivery. And I assume, although I've never seen any reports, that it could happen with a D & X procedure just as easily.

Q. Does the type of abortion procedure make any difference in whether or not a woman would have [p. 35] amniotic fluid embolus?

A. I don't believe so. It can occur in any of those conditions. And because it's so rare, I know of no study that would show that one technique has a higher incidence than another. All of them have that risk, including labor and delivery of a term baby at the time of normal delivery.

Q. Would it be fair to say that it's simply a complication that the treating physician has to be aware of and deal with if it arises?

A. Exactly.

Q. But the selection of the method of procedure you're saying does not enhance or increase that particular risk of amniotic fluid embolus?

A. I don't believe so.

MR. SMITH: Nothing further. I would offer Exhibits 23 and 24.

(Exhibit 24 marked.)

MR. HELLER: No objection.

(Off the record.)

EXAMINATION

BY MR. HELLER:

Q. You gave some very eloquent testimony in response to Mr. Smith's question about your experience [p. 36] prior to *Roe v. Wade*. And you talked about particularly poor women being affected by the unavailability of legal abortions. Do you recall that testimony?

A. Yes.

Q. Do you favor Medicaid funding for abortions?

A. No.

Q. Even though that might affect the ability of poor women to obtain legal abortions?

A. It may affect it. I think those of us – I'll speak for myself – that have always felt that the government should not pay for abortions basically because of the considerable diversity of opinion on the subject in this country, it is to respect those who consider abortion to be murder. And I've always felt that if common ground on this subject was ever to be achieved, it was to at least show some respect for those sincere individuals who are opposed to abortion because I don't believe they're any more wrong than I am wrong or right either. So it has always been my contention that asking their tax dollars to be used to pay for abortion was sort of a slap in their face and felt that those of us who were pro-choice needed to step up to the plate and [p. 37] contribute to those organizations that perform abortions.

And I have been espousing that for years and have lived up to that by considerable financial contribution to our Planned Parenthood here in Nashville, for example, for that very purpose. Realizing that there are problems with that, which I'm sure you could get into, I think this is the best course of action that I could come up with in trying to: A, find common ground; B, not be offensive to too many people and yet at the same time not preclude poor women from being able to obtain an abortion.

Q. From a medical perspective, however, would you concede that if in fact the lack of Medicaid funding precludes some women from obtaining legal abortions that it's medically harmful based on your experiences prior to *Roe*?

A. Well, if they don't get the abortion because they can't come up with the 2- or $300 and they go get a back alley abortion, then the answer clearly would be yes.

Q. You talked about – I think in general in your direct testimony about the need for a framework and guidance within the medical community on the abortion subject?

[p. 38] A. Yes.

Q. And I assume that applies generally to other medical issues as well?

A. Sure.

Q. Why in this arena do you believe that the general opinion of medical professionals like yourself and of the medical community as a whole is insufficient and that legislation with criminal penalties is required?

A. Interesting question. I would have hoped that the medical profession wouldn't have even brought this particular type of procedure up so as to give ammunition to those in the pro-life movement who then would use it against the movement, itself; that is the pro-choice movement.

But the fact is that there are a group of doctors in our country – and I don't know the exact number, but I know there's 37,000 obstetrician/gynecologists in this country – and I would dare say that there's more than a handful that are proponents of this procedure or perform this procedure. Maybe it's more than a handful. I don't know. But because of their performance of these procedures and because the performance of these procedures have gained public access by the television [p. 39] set, the senate floor

description, newspaper and television description, it has created a situation in this country where people have had to actually ask the question, What's going on here?

And because of that and because of what I think is a need for the medical profession to put some limitations on what we do so as to not give the impression that those of us who believe in pro-choice are extremists, I think certain guidelines need to be applied.

I would liked [sic] it to have been just a medical guideline, but since that didn't seem to work, the political arena got involved, and politics of it produced laws such as LB23 and HR1122 and Tennessee's statute which those of us who have an opinion on this matter had to take a side. I took my side, and I'm defending it this morning with you.

Q. I understand. In terms of medical guidelines developing, is it your understanding that there was an effort made to develop medical guidelines for abortion procedures in general?

A. There have been periodic attempts. We've done – we've done that locally, and I would imagine that the American College of Obstetricians and Gynecologists have at some point addressed that. I [p. 40] have never seen any written guidelines. That would have perhaps been useful years ago before partial birth abortion reared its head so to speak. But certainly here at Vanderbilt we have done that addressed the guidelines.

Q. How could you expect guidelines to develop before people know about the procedure being done?

A. Well, you can devise guidelines that take into consideration more than just procedures. You can address, A, the gestational age limits, the reasons for doing the abortion, you can accept guidelines or devise guidelines that deal with the known study procedures. For example, every procedure that I have listed earlier that I have performed, there have been research attached to that. Using that research in the safety of the procedure, guidelines come forth from that experience.

Q. Do you consider the D & E method, which was referred to in your direct testimony, a safe method of abortion?

A. I do.

Q. Does it become a different method – well, first tell me what occurs during a D & E procedure.

A. A D & E is a procedure usually done at 16 weeks, 14 to 16 weeks, occasionally 18 – and I have [p. 41] heard of them being performed as late as 20 weeks – where the cervix is dilated using the dilatation tools and instruments then placed inside the amniotic cavity to remove the fetus to – with terms such as dismemberment. These are usually done under some type of sedation and anesthesia, occasionally under general anesthesia, and often with ultrasound guidance so as to avoid complications of perforations.

Q. Would it be a significant variant of a D & E if you decided to, in dismembering the fetus, dismember the legs first and then the rest of it later? Would that constitute a new abortion procedure?

A. No. When one reaches into the cervix, into the uterus to obtain a portion of the fetus, one never knows what portion that individual is going to remove.

Q. Even with ultrasound guidance?

A. Well, you can be a little bit more specific, but it is very difficult to be able to choose, even with ultrasound guidance, what portion you're going to remove first. It is a procedure that is not done that frequently. As you know, over 90 percent are done with a first trimester D & C where that is not – that is not a D & E by any means. And of the second trimester abortion, which is 10 percent of the 1.2 million abortions, I'm not sure exactly what [p. 42] percentage of D & E versus prostaglandin or other types of techniques, but it's not that commonly performed in this country.

Q. Do you have that Exhibit 7 that we looked at before? If you would look at what's marked at the top as page 7 on this document, a chart called Percentage of Reported Legal Abortions, do you see that?

A. Yes.

MR. SMITH: Just for the record, you're referring to Exhibit 7?

MR. HELLER: Exhibit 7 from the trial or from an injunction hearing.

BY MR. HELLER:

Q. What percentage of abortions are reported as being done by labor induction from 16 to 20 weeks gestation on this chart?

A. Approximately 9 percent.

Q. So and then 86 percent are by D & E; is that right?

A. Yes.

Q. So the vast majority are done by D & E after 16 weeks?

A. Yes. My comment about uncommonly had to do with the entire number done. But as far as the [p. 43] procedure at 16 to 20 weeks, the D & E is done more often than the labor induction.

Q. About ten to one?

A. In this particular study it's about ten to one, yeah.

Q. Do you know what the source of this information is?

A. I would imagine it's CDC information that is reliable.

Q. I think the chart indicates reported by 35 states?

A. Mm-hmm.

Q. And then after 21 weeks, is labor induction the most common procedure after 21 weeks?

A. It's still the same percentage. It's 86 versus 9.

Q. So it's most common even after 21 weeks?

A. Even after 21 weeks.

Q. Does that conflict with your understanding of what was going on in the United States with abortions after 21 weeks?

A. I think it's a little higher than I would have expected, but it doesn't overly surprise me. The trend toward labor induction has increased. This was states reporting six years ago, and I think the data is [p. 44] probably different, but it doesn't change my opinion on it. I think the D & E is still a safe procedure. We're talking still about a small number that are greater than 21 weeks –

Q. A small, absolute number?

A. Right.

Q. I understand. Do you recall saying that you didn't – do you recall saying earlier this morning that you didn't think doctors really did D & E's after 20 weeks?

A. There are not many. I don't know the exact number that are greater than 21 weeks that are done.

Q. Well, I'm not talking about the whole, overall number, but it seems that of those that are done, the majority are done by D & E's?

A. That's correct, but that's still a small number of physicians that are performing them. We don't do them here in Tennessee after 20 weeks that I know of. In the Middle Tennessee area, it's usually no more than 16 to 18 weeks.

Q. Now so when you do abortions after 20 weeks here, you're using the less common method, the labor –

A. From the 1992 data, that's correct.

Q. And if someone banned that method, that would affect your practice, wouldn't it?

[p. 45] A. Sure.

Q. Talking about going back to the D & E itself, if you grabbed hold of a part of the fetus, which I assume is done with forceps, and pulled out the entire fetus in one piece, would that be a variant? Would that be a new abortion procedure or just the way it happened in that particular instance?

A. The latter. It wouldn't be a variant. It would be just something that happened.

Q. And then if you did that once – I'm using you meaning you generically, not you personally – and thought about it, would it be reasonable to conclude that by removing it in one piece, there is less risk of leaving fetal tissue behind?

A. Sure.

Q. And would it be reasonable to conclude that there's less risk of sharp fetal fragments puncturing the uterus?

A. Sure.

Q. And therefore would it be reasonable to conclude that removing the fetus intact might be safer for the woman?

A. Might be.

Q. But you'd need a good study to determine whether it really was?

[p. 46] A. I think that's a reasonable statement.

Q. Do you oppose elective abortions?

A. No.

Q. You indicated this morning I believe that sometimes you might get a woman who wanted an abortion done by D & E later when you don't do them and so you'd refer them elsewhere. Do you recall that testimony?

A. Yes.

Q. And you indicated you would refer her, among other places, to Dr. Tiller; is that right?

A. Yes.

Q. Does Dr. Tiller do abortions after viability?

A. Yes.

Q. You also testified that you consider abortions after viability immoral; isn't that right?

A. I do.

Q. When you refer to Dr. Tiller, do you feel like you're referring to an immoral doctor?

A. I explain to the patient that I am opposed to abortion after viability. Those few patients who found themselves in a situation, for a variety of reasons, with significantly malformed fetuses desiring an abortion and having explained to them that that abortion cannot be done in Nashville or Middle [p. 47] Tennessee, when they say, Isn't there anyone in this country, I admit to them that there are physicians who will perform the abortion all the way up to 36 weeks. And while I don't agree with

it and that I have a problem morally with it, I feel that it is my duty to give them the information so that they can carry out their autonomy – their autonomous – I'm at a loss for a word.

Q. Moral agency or something?

A. Thank you. Thank you. That's something that they certainly know that I don't approve of it, but I don't feel that I can not tell them about the doctors in this country that do offer that. That's part of my responsibility to let them know the options. And most of them have taken that information and used it.

Q. You testified this morning in our nonvideo deposition that the last time you've done a D & E yourself was about ten years ago?

A. Yes.

Q. Then in the second part you said at least ten years, so I'm trying to get a sense. Is it maybe more like 15 years?

A. You know, I really don't remember. 10 or 15 years when you're 57 years old sort of lumps [p. 48] together. I have helped some of my partners who do D & E's, especially when complications have arisen. But I, myself, have not taken a patient and scheduled her for a D & E and then performed it as the single provider in at least 10 years. It could even be 15. And my reasoning for that is again individual and based on my own autonomy preferences.

Q. I understand. How many D & E's have been performed with live fetuses, that is where there hasn't

been fetal demise, here at Vanderbilt Hospital as far as you know over the past ten years?

A. Probably less than 100 but a significant number.

Q. So maybe ten per year?

A. Oh, easily.

Q. Do you feel like you're in touch with advances that have occurred in the D & E method over the last 10 to 15 years?

A. Probably not. When you don't perform a procedure, you lose touch. I read the literature, but I think it's safe to say if you don't do a procedure for whatever reason, you can't consider yourself as much of an expert as someone who does them on a routine basis.

Q. What I'm trying to get at with this is it [p. 49] seems to me that – and tell me if you agree with this – that doctors operating, doing the later D & E's after 16 weeks, say, might through practice through surgical trial and error discover that they believe that it's easier, safer to remove a fetus intact, feet first with the after-coming head and then decompress the head either by crushing the skull or by removing the contents of the cranium because it involves less instrumentation and it involves less risk of fetal tissue being left over, perhaps less sharp fragments from the fetus.

Wouldn't that ordinarily – if we were putting out a picture that some people consider this another human life, wouldn't that sort of be the way that surgery evolves over time, that people try new things and feel that it works better but it isn't a big departure from what they'd done before?

A. I think you have a point. But where you lose me in the argument is if you take away the other aspects of the procedure as far as the moral and ethical precepts of the procedure, number one; and number two, something that I think needs to be addressed and I haven't mentioned it yet, and that is the effect of the procedure on, A, the individual performing the procedure; B, the nurses and other [p. 50] health care providers in the room assisting with the procedure; and C, the patient herself along with her family.

These have profound effects on the health care provider, for example. It had its effect on me with just the D & E procedure, and that's why I stopped doing those. I'm not opposed to them, but I, using my autonomy principles, decided not to do those anymore. But because I felt they were safe and because I felt that they represented a practice that was studied now and acceptable and reasonably safe that it would be a procedure that I could support in general, even though I didn't perform them, myself.

But I don't think you can remove that aspect of the effect on the health care provider and the patient, the effect on the morality issues for the public, the ethical issues for the public, from the argument that, well, if we could prove that it was safe, wouldn't it be a better technique?

I don't think all medical research should be performed without considering the ethical precepts of that study. And that's why there are human investigational committees in every hospital looking at the propriety of a study. Is it scientifically appropriate? Does it violate

informed consent? Does [p. 51] it exceed what this committee believes to be ethically and morally appropriate?

And if the answers to all those questions are no, it doesn't, they're fine, then the research can go on. But just to do a procedure and to do a small study without – formal study without peer review either before the study is begun, during the study, and then after the study, in my opinion is improper.

Q. Let me just be clear about this because my question was putting those concerns aside.

A. But how can you put those concerns aside? They're wrapped together. They're intermingled in a way that precludes them to be separate.

Q. Well, let me give you a hypothetical.

A. Okay.

Q. Suppose someone needs to have a kidney removed. And I understand you may have never removed someone's kidney; is that right?

A. Well, that's not true. I actually have, but you don't want to get into that.

Q. If someone – if in prior practice the practice had been to remove the kidney in pieces and then someone said, What are we doing it this way for? Let's remove the whole kidney in one piece because then we don't have to keep sticking the instruments in [p. 52] there, and – now, again, I'm not asking you to make the comparison. I'm asking you to tell me whether you think it would be reasonable from the standpoint of the patient's health to

make the assumption that that procedure in which the entire kidney is removed at once may somewhat be safer.

A. Well, I would turn it around. Anyone who knows anything about medicine, – and I don't mean to demean your knowledge of medicine because you were trained in the law and I was trained in medicine – it would be much safer to remove a kidney in whole than it would be in parts because as you start to chip away at the kidney, you start getting into bleeding.

The mother then or the father or the human that you're doing that would bleed to death. So anyone who knows anything about medicine would first say, Let's take it out whole. If you turn the argument around somehow – and it would be very hypothetical – that taking it out in whole has been the practice and somebody thought, Let's take it out piece by piece, then at least it makes more sense although I could hardly enjoin that argument because I know it would not be. You're equating a kidney with a fetus.

Q. I wasn't trying to –

A. No, but you do. If you want to make a [p. 53] hypothetical, it's just not a good hypothetical. I might could help you with something else with a different kind, but that's just not good because taking out a kidney piece by piece would more than certainly kill a large number of humans, and taking it out whole would make the most sense.

Q. I understand your objection to my hypothetical.

A. Okay, thank you.

Q. Let's get back to the situation we're talking about. Let's talk about a D & E versus what I'm going to call an intact D & E which is where you remove the fetus intact.

A. Okay.

Q. Is it your understanding that the Nebraska legislation prohibits intact D & E?

A. As I read it I believe that to be true, yes.

Q. And do you consider the intact D & E vastly, morally – let me say do you consider the intact D & E more morally objectionable than a D & E in which the fetus is dismembered?

A. Well, now that's a very good question because I've had to deal with that, and I don't – I do see a difference. I'm troubled by the D & E, intact or [p. 54] otherwise. But I am willing to admit that the intact D & E has caused a considerable dilemma for all sides of the matter on abortion, pro-choice, pro life, and the public in between. I have a problem with both.

But because D & E, assuming that it's done before viability and with the proper techniques, I believe has been proven to be safe and therefore is a technique that should not be banned as partial birth abortion has been banned.

Q. Well, but isn't the intact D & E just a variation of the D & E?

A. It is a variation, assuming that it's done before viability, as you know –

Q. Yeah, I'm talking about before viability.

A. I believe it is a variation of it, but that's not the issue that was before the American public. And the D & E did not come before the American public in the same way that the intact D & E or the D & X did. And so we're dealing with the D & X. What society wants to eventually do with the D & E at some point is hard to guess.

And those of us who work in this field will have to address that issue when it arises, if and when it arises. But certainly at this point I don't have a problem with states setting certain limitations, [p. 55] especially if they're not unduly burdensome. Removing this shows responsibility of the state and shows some commitment to allowing for limitations that would not erode maternal health or the health of women having abortion and at the same time placate some of the severe criticisms of those individuals who are performing the procedure.

Q. That made me think of a lot of questions.

A. Okay.

Q. Do you think if these statutes were all upheld, the opponents of abortion would be placated and just say, Okay, we're done?

A. Oh, no. And as a matter of fact, I've told my pro-life friends who have used some of my attitudes to their benefit that once we change the viability definition in Tennessee that I think they have lost me as anyone that would support the arguments. I think gestational age limits and types of procedures are things I'm interested in.

But I want in no way to erode further the ability of women to obtain a safe abortion. And that would include all the procedures that we've talked about other than the intact D & X.

Q. Would you favor banning the D & E abortion?

A. No, I would not favor it.

[p. 56] Q. You testified that you were – part of your support for this legislation is because there are safe alternatives available; is that correct?

A. Yes.

Q. Do you know if there are safe alternatives available in Nebraska?

A. I've never practiced in Nebraska, so there's no way for me to know. However, using the definition of geographical standard of care and knowing that our colleagues pretty much practice reasonably similar approaches to medicine, I have no reason to think that it would be any different in Nebraska as it is say here in Tennessee.

Q. Well, hypothetically if it turned out that there were no hospitals in Nebraska, unlike Vanderbilt, where a woman could obtain an elective abortion at any stage of pregnancy, would that change your opinion about the availability of alternatives?

A. Oh, no. I'm aware of the fact that 84 percent of the counties in the United States do not have abortion services. I am very aware of the decreasing number of abortionists in this country. Only a small percentage of – I think a third of the residents that we train even get any

training in abortion. I'm aware of the inequities of the services [p. 57] that are available.

Having said that, that doesn't allow me then to take that and have it be a reasonable argument against the moral and ethical precepts of this particular procedure of an intact D & E.

Q. I want to ask you a different sort of question. The plaintiff in this case is a man named Dr. Leroy Carhart. And there's been testimony that he performs several different procedures, depending on gestational age of the fetus, and that he attempts to remove a fetus intact during the D & E procedure and that he believes that's safer for the women he treats.

To what extent does your opinion about the availability of safe alternatives – to what extent is that affected by the doctor's own assessment of what he or she is best skilled at? In other words, if someone said to you, No more prostaglandin inductions, you've got to do only D & E's from now on, would you stop doing abortions? Let me ask that first.

A. I might. I might.

Q. Wouldn't that then affect women's access to abortions?

A. It might. I'm not a sole provider of abortions in the state of Tennessee, and I would imagine your plaintiff is not the sole provider of [p. 58] abortions in the state of Nebraska.

Q. Well, actually there's testimony that he is the sole provider after 16 weeks of pregnancy.

A. Well, I maintain that those arguments, while valid, do not reach the level of significance that overrides the other issues that I've already enumerated on a number of times.

Q. And if I understand that issue correctly, it's that you believe that intact removal of a fetus during a D & E is more morally objectionable than dismemberment. I'm trying to get a sense –

A. No, I understand. You're asking the right questions, and I appreciate what you're doing. But I don't think it's just a matter of intact removal as opposed to dismemberment. I think you're talking about more than just intact removal because what you often have is a fetus that is dangling nine-tenths of the body outside the vagina with legs and arms frailing (sic) and then a stiffening up when the trocar is put into the base of the brain to suck out the intracranial contents.

Q. Excuse me. What do you base that on?

A. The description of numerous sources of those who have written about the procedure and witnessed the procedure.

[p. 59] Q. In medical journals?

A. In a variety of journals but not medical journals.

Q. In the press?

A. I read them in the press. I have read testimony by nurses. I have read in the New York Times magazine by reporters.

Q. Are those the sorts of sources you would ordinarily –

A. Well –

Q. Let me finish – you would ordinarily rely on to form your medical opinions?

A. Oh, of course not. On the other hand –

Q. Well, that's important.

A. I'm not going to go view such a procedure just so that I can find out whether what I read in other journals is true or not.

Q. I understand. I'm just trying to get a sense of what you base your conclusions on. But you said nine-tenths of the fetus or baby is dangling outside the vagina?

A. Sure.

Q. Is it your understanding that there's a requirement in the law that the fetus be outside the vagina? Couldn't it be in the vagina?

[p. 60] A. It could be. What happens is usually as the fetus is delivered, a significant portion – maybe I misspoke myself with the use of 90 percent. A significant portion of the fetus is outside of the vagina. Otherwise, it's difficult to put a – I would imagine it was difficult to put a needle or trocar through the base of the skull underneath the cervical realm.

Q. Is it correct that the reason to do that, to insert the trocar would be to reduce the size of the head so it could come through the cervix?

A. Exactly.

Q. Now how do you get the head of a fetus out in a regular D & E if it doesn't fit?

A. Well, usually the skull is the last portion of the fetus to be brought through the birth canal, and it is usually after the fetus is dead obviously. Instruments are used to grab the fetal skull, and it literally crushes the bone to bring it through the cervical canal.

Q. And you find there to be a significant moral difference between doing that and a standard D & E and doing it when there is this dangling significant portion?

A. In the partial birth abortion the fetus is [p. 61] alive. In the crushing of the skull to remove the fetus in the D & E, the fetus is not alive.

Q. Well, let's get to the question of what – and we talked about this earlier this morning. The Nebraska statute uses the term "substantial portion," and you testified earlier that you consider that to be something more than a hand or a leg; is that right?

A. Right.

Q. But you also concede that some people might consider a hand or a leg to be a substantial portion?

A. I'd concede it that way.

Q. And that in fact in an ordinary D & E, a leg could be removed and the remainder of the fetus could still be alive for a brief moment?

A. Correct.

Q. And that if the broader definition of "substantial portion" were adopted that D & E's could be prohibited by Nebraska law?

MR. SMITH: I'm just going to object just because of your terminology, the broader definition, I don't thick [sic] it's clear what you meant.

BY MR. HELLER:

Q. Oh, absolutely. The definition of substantial portion there would include a hand or a foot or a leg or an arm. But if that definition is the [p. 62] one, then D & E's could be prohibited by the Nebraska law?

A. Anything is possible. I just don't know – it can't reach the level of probability for me because it's never been tested.

Q. What I'm asking is if the Nebraska legislature had said "substantial portion" means a head, an arm, a leg, a foot, a hand, then we would have some clear idea of what it means, right?

A. I doubt that I would thence be able to support the Nebraska bill if it had gone that far to describe that. We had the same problem in Tennessee, and it was my reliance on the terminology of "substantial" that allowed me then to support the bill because I had no desire to outlaw – while I may disagree with the D & E, I in no way wanted to outlaw the procedure itself.

Q. Well, let me give you another hypothetical. Do you currently – you indicated you use prostaglandin induction methods for abortions here?

A. Yes.

Q. Suppose Tennessee passed new legislation and it said that no prostaglandin abortion may take place if the procedure lasts for a substantial period of time. That was

all they said. And they would – if [p. 63] you – if the procedure did last a substantial period of time, you would end up facing felony penalties here in Tennessee. Would you have concern that the various possible meanings people could ascribe to the phrase "substantial period of time" would put you at risk for prosecution?

A. Well, without getting into all the objections to the hypothetical, I think the answer would be yes.

Q. And if you were doing D & E's, wouldn't you be concerned that maybe you would – maybe you are removing a substantial portion because it's not defined within the statute and you might go to jail for doing that? If someone later on said it does include a leg?

A. I understand that any bill that tries to be exact has a certain element of vagueness, and I am willing to accept that for the greater good of developing moral frameworks of the process of abortion. But I can't argue with you that these vague – some of these terms that are considered vague can be defined differently. And "substantial" obviously is an important word.

I'm hoping that once these laws are passed that the procedure of D & X or intact D & E will not be performed and that no doctor will be prosecuted for [p. 64] doing a D & E where a portion – a substantial portion is considered a small anatomical part of the fetus.

Q. Have you seen any documents from the sponsor of the federal bill indicating that he didn't believe that the federal bill applied only to D & X abortions?

A. Yes. Well, the original bill at the federal level clearly involves D & E.

Q. I mean the more recent version that was vetoed by the President?

A. Yes, it included D & E as far as I can tell.

(Off the record.)

BY MR. HELLER:

Q. What sort of documents, if any, did you review before today's testimony?

A. Nothing really. Counsel showed me the Nebraska statute which I had already seen, the ACOG bulletin stating the policy right before deposition again which I knew about and have seen and read, and the AMA's Exhibit Number 7 that I had also seen and read before.

Q. You didn't review any of the legislative history under Nebraska law?

A. No.

[p. 65] Q. You had looked at the ACOG statement, which is Exhibit 24, earlier and you testified about that and about some of the language in there. Would you agree that someone at ACOG, some people believe that the D & X procedure may be the most appropriate procedure in some instances?

A. I do.

Q. And so at a minimum there's a division of medical opinion about whether it's an appropriate procedure or not?

A. Sure.

Q. And there was a similar statement in Exhibit 7 that you looked at from the AMA, a statement about it being an appropriate procedure or perhaps safer because it reduces trauma. Do you agree that it may be safer because it reduces trauma?

A. Well, "may" is a very big – allows for a lot of leeway, so if there's no studies to show, of course, it's theoretically possible and therefore may.

Q. But before there are studies, people go based on their general surgical experience, wouldn't they, in making modifications to a surgical technique?

A. Well, that's true. But again, I said it's hard to – it's hard to dissect or separate the other issues with this particular procedure, not only the [p. 66] moral and ethical precepts which I've outlined, but the public reaction to it and the ramification. Already in this country we have seen, because of the controversy of D & X, that there has been a significant drop in public support for abortion.

So the pro-life movement has clearly done an outstanding job of public relation-wise by putting this D & X procedure up before the American people, has been aided by the pro-choice movement which refuses to address the moral and ethical framework of the procedure of abortion and therefore has eroded the support that I think pro-choice movement needs to maintain.

And so it's my firm belief that had the pro-choice movement and the medical profession said, Of course, this is something we shouldn't do, the issue would have been dropped and that public support wouldn't have

dropped 8 percent which it has been just recently shown to have been dropped.

Therefore, I persist despite the fact that some of the arguments you make are reasonable. And while some of my arguments are not totally without some flaw and some inconsistencies, I believe that what Nebraska has done and what Tennessee has done and what a number of other states have done with that particular [p. 67] wording comes about as close as we can hope for in demonstrating to the public that the medical profession and the states are willing to state certain moral and ethic frameworks of how we offer and administer the process of abortion.

Q. I was provided with – it's a faxed version of a letter signed by you, addressed to a Dr. Levine or Levine, Mark Levine. Do you recall that letter?

A. Yes.

MR. HELLER: Does that – and actually I guess I could get it marked.

(Exhibit 25 marked.)

BY MR. HELLER:

Q. Do you recall that letter?

A. Sure.

Q. And does it accurately summarize some of your views about partial birth legislation?

A. Yes.

Q. On page 2 of that letter you state – you wrote at the very bottom, "It is my opinion that such a procedure

should be banned so as to comfort the general public in this country that abortions are not in the hands of callous extremists."

A. Yes.

Q. Is that still your view?

[p. 68] A. Yes.

Q. And do you think that's a significant basis for your support for this legislation?

A. Yes. Significant or substantial?

Q. I'll leave that to you. If you don't feel comfortable with the word "significant", we can use a different word.

A. No, I'm comfortable.

Q. No one goes to jail here if you use the wrong word or if I do.

A. I'm comfortable.

Q. Okay. I want to go briefly back to the woman who wants an abortion at 22 weeks. And let's assume that what you understand to be partial birth abortions are not prohibited, so she can choose – and that she's in a state with a lot of abortion providers. So she could choose a prostaglandin induction procedure. She could choose a standard D & E involving dismemberment. She could choose an intact D & E. She could even go to someone who will do the exact procedure in the ACOG definition involving conversion of the fetus, if necessary.

What in your view from a medical standpoint – and I want to talk about safe – if you could talk about physical

safety risks. What do you [p. 69] believe justifies the State in prohibiting one of those options and not all the others or picking one out and saying, This one we're prohibiting; the others, go right ahead, to the woman?

A. Well, I believe you've gotten my response on that because if you would have asked me that question, whether there's any difference that we know of in medical complication rates or injury to the mother, we really don't. They would all be acceptable medically. But as my letter indicates and I have stated many times before, the other procedures are not before the American public.

The other procedures have not reached the level of concern by lawmakers, by the general public, and by the medical profession. And so with that particular aspect in place, it's reasonable for the State to respond to the fear and concern of the public and the health care providers who are severely or significantly opposed to this type of procedure to ban it.

The corollary would be to say that the State has no right to ban any procedure that the public believes to be immoral and unethical and disgusting. If our society continues with doing anything it wants, eventually all abortions may be eliminated. And that [p. 70] will come about because the American population has made up its mind that abortion is wrong, regardless of the reason and regardless of the technique, and *Roe v. Wade* will be overturned. That will be a public domain. That will be a public phenomenon that will not be brought about by individuals such as me.

My role is to try to defuse the fervor so that Americans and the 70 percent who believe that abortion should

be kept legal, safe, and rare will maintain to be the majority so that *Roe v. Wade* will not be overturned and the majority of women will still be able to obtain a safe and facile and accepted abortion.

Q. But all of that is in essence, isn't it, your personal opinion, your political opinion?

A. Well, of course, absolutely. You're getting nothing but Frank Boehm here. You're not getting anybody else.

Q. Okay. This morning we spoke briefly about the lack of a statistical study on say the intact D & E variant of the D & E, and you said you didn't know of such a study; is that right?

A. That's correct.

Q. And didn't you also concede though that if the procedure is banned, there is unlikely to ever be [p. 71] such a study, at least in the United States?

A. Right.

Q. So we might never know if it's even 3 percent safer?

A. Might never know.

Q. And women might be deprived of a procedure that's 3 percent safer and they would never know that they were deprived of it; is that right?

A. That's correct.

Q. Even when used pre-viability?

A. Correct.

Q. You also testified earlier about doing terminations of pregnancy after 24 weeks, but you don't call them abortions; is that right?

A. That's correct.

Q. And you do those procedures in cases of lethal fetal anomalies?

A. Sure. The definition of an abortion is the delivery of a fetus with the intent to deliver a dead fetus. If our intention is not to deliver a dead fetus, then it's not an abortion. It's just a termination of pregnancy. And if the diagnosis is a lethal one such as renal agenesis or anencephaly, then the fetus dies during the delivery process or immediately thereafter.

[p. 72] This is not an abortion. This is a delivery so as to help the psychological aspects of a woman knowing she's carrying a fetus that will not survive as well as reducing some of the complications of allowing a pregnancy to continue.

Q. You also testified that you thought one reason justifying the partial birth abortion ban was the possible effect on the emotional health or moral health of nurses, providers, and the women themselves. But you have no statistical or even anecdotal support for that, do you?

A. Only in what I've read in the lay press and journals, nonmedical journals, and my experience with health care providers who participate in a procedure that is not banned but has certain elements of unpleasantness such as the D & E.

Q. But just to be clear, that's not really your expert opinion as a medical expert, is it?

A. No, not at all.

Q. And – almost done. You indicated that you teach abortion techniques here?

A. Yes.

Q. Which techniques do you teach?

A. The suction D & C, the sharp D & C, the prostaglandin abortion, and the hysterotomy and the D & [p. 73] E. I don't personally teach D & E, but my partners do.

Q. And is it you don't teach the D & E because to some extent you find it offensive?

A. I don't perform the D & E, so I can't teach something I don't perform. If one of my partners needs some help, I'll be there to help during a process of complication. But they don't have the same problem I do, so they perform them and I don't.

Q. When you – shortly after *Roe v. Wade* when a woman would want a second trimester procedure say at 14 weeks, what procedure was used?

A. A D & E.

Q. What about at 16 weeks?

A. Usually we went to saline abortions or intraamniotic prostaglandin or intraamniotic glucose.

Q. Do you do saline abortions now?

A. No.

Q. Why is that?

A. We have better techniques and techniques that are not associated with as high an incidence of problems

such as coagulopathy and saline – inadvertent intravascular injection of saline which has resulted in maternal deaths. Complication rates I think is the biggest – also the concern of the burn of the fetal skin over a period of time and the perception of pain [p. 74] problems. I think the prostaglandin allowed us to move away from those procedures and move toward a procedure that more of us who were pro-choice felt we could live with.

Q. And in addition, one that was perceived to be safer or is safer?

A. Good question. I don't think anyone has compared saline with intravaginal prostaglandin which is what's used today, but I would think it's safer from what – this would be anecdotal experience over years of performing both, that the saline was not as safe as the intravaginal prostaglandin procedure.

Q. So in that case even though there might not be statistical studies, you felt comfortable making that transition?

A. I did, yes.

Q. And also there was a transition, wasn't there, to doing more – to doing D & E's later in pregnancy than initially they were done?

A. Yes.

Q. And if someone at that point had banned D & E's, we wouldn't know today whether that method was safe or not safe; is that right?

A. That's true.

[p. 75] Q. If a woman – going back to the example of the woman facing the various options for a 20- or 22-week abortion wants to weigh the risks and benefits of each procedure as part of her informed consent process, to what extent does removing one option interfere with her informed consent?

A. I think if they have reasonably safe options that it doesn't interfere with it at all.

Q. I'm sorry. Does not?

A. Does not interfere.

Q. So that a woman who says, Well, I'd rather not have a 12-hour period of contractions and cramps. I'd rather have a D & E. If the D & E were the banned procedure, it doesn't affect her informed consent not to have that other option, even though the other one –

A. It doesn't affect her informed consent. First of all, the D & E is not what we're discussing. We're talking about the D & X. And hypothetically we have no discussion on the table to remove the D & E. But I think that when women get to the point where they're 20 weeks pregnant or 22 weeks pregnant, assuming that for whatever reason that the abortion is being planned, this is not a perfect world and we can't offer perfect solutions to make everyone happy and to do this quickly and without any emotional distress.

[p. 76] Whether it's 12 hours or 24 hours or occasionally 36 or 48 that we've had to use to effect abortion with prostaglandin, I don't think it's fair to try to compare the procedures and say because one is a shorter or one appears to be quicker that one is superior to the

other. They're all difficult for patient and health care provider alike to undergo. And removing the D & X in my opinion doesn't inhibit a safe alternative.

Q. But removing the D & E would?

A. At this point I believe that it would, yes.

Q. And wouldn't also removing the D & E interfere with the woman's choice method?

A. Probably.

Q. Just like you can decide to get – a doctor can present you with chemotherapy for cancer and radiation therapy and tell you the advantages and disadvantages of both and the patient chooses?

A. I think that's reasonable to state, yes.

Q. Okay. I brought that up because of your background you indicated in medical ethics, and I think that's –

A. Sure.

Q. – an aspect of this if we – you know if we look at just the choice of method.

[p. 77] (Off-the-record comment.)

BY MR. HELLER:

Q. You indicated that you believe the choice, the abortion choice needs some limitations?

A. Yes.

Q. And indicated that this is one of those limitations that you support. Can you tell me, are there any others you support?

A. Yes.

Q. What are they?

A. I support one-parent consent in minors with a judicial bypass procedure in place. I support a 24-hour waiting period from counseling to procedure. I support gestational age limits, not to be performed once 24 weeks has been achieved. I support private funding for the poor rather than government funding for abortions. And I obviously support certain procedures such as partial birth abortion bans. But that's it.

Q. Do you recall signing a sworn statement that a three-day waiting period in – sorry. I have the wrong ending to this. One second, please. I'm sorry. I had the right one. Do you recall signing a sworn statement submitted in Circuit Court of Davidson County in Tennessee in 1992? I'll quote and you can tell me if [p. 78] you remember: "The three-day waiting period mandated by the statute provides no benefit to a woman seeking abortion."

A. I'm sorry. Could you read it again?

Q. Sure. "The three-day waiting period mandated by the statute provides no benefit to a woman seeking an abortion and will only make obtaining abortions more difficult and expensive, especially for poor women who may have traveled to Nashville from rural areas in order to obtain an abortion." In addition, in many cases this waiting period requirement will prevent women from obtaining abortions at all. For these women waiting the three days prescribed by the statute will take them past the term of pregnancy 14 weeks LMP, during which

Planned Parenthood will perform an abortion. Abortions after this period are unavailable in Nashville for women with healthy fetuses. Do you recall –

A. Oh, yes, and there's a big difference between 72 hours and 24 hours.

Q. So you support 24 hours?

A. I have decided that I can support 24 hours.

Q. I could not support more than 24 hours.

Q. Do you support a requirement that abortions after the first trimester of pregnancy be performed in [p. 79] a hospital?

A. After what gestational –

Q. After the first three months of pregnancy?

A. No. I think you can go up to about 14 weeks safely in an outpatient clinic. That's just a couple of weeks different. It depends on how you define first trimester. I define it as to include 14 weeks.

Q. But after 14 weeks it should be done in a hospital?

A. I believe that to be true.

Q. And you support a statute that would say that?

A. I don't have a problem with a statute that supports that.

Q. Do you support a requirement that physicians provide informed consent for abortions personally?

A. Yes.

Q. Did you support that in 1992?

A. Well, you didn't give me an alternative, I guess. I think a physician should obtain the informed consent. I also am aware that a lot of informed consent initiates from other health care providers. But I believe a physician should at some point in the [p. 80] process before doing it, should sit down and talk to the patient.

MR. HELLER: Can you mark this as Exhibit 26?

(Exhibit 26 marked.)

BY MR. HELLER:

Q. Can you take a look at it and tell me if you remember this? I apologize for the pages going over two pages. I think they were originally eight and a half by fourteen pages.

A. I remember this.

Q. If you want, just check the last page. Is that your signature on the second-to-last page?

A. Yes, that's mine.

Q. This was your sworn statement back in 1992?

A. Yes.

Q. Have your views changed?

A. I don't know. I need to read it again. Can I get a copy too?

MR. HELLER: Sure. I think I'm done except I want to move the admission of 25 and 26. You may want to look at 26.

MR. SMITH: No objection.

(Off the record.)

[p. 81] REEXAMINATION

BY MR. SMITH:

Q. Exhibit 25, which is a letter you wrote to Dr. Levine, you wouldn't have been under oath obviously at the time you wrote that. But as you sit here under oath now, do you adopt all of the opinions and the statements in there as being true?

A. Yes.

MR. SMITH: Okay. Nothing further.

(Deposition ended at 1:15 p.m.)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 32

DEPOSITION OF
FRANK HENRY BOEHM, M.D.
Friday, January 23, 1998

* * *

[p. 2] The deposition of FRANK HENRY BOEHM, M.D., was taken by counsel for the Plaintiff at the offices of Dr. Boehm, Vanderbilt University Hospital, B-100 Medical Center North, Nashville, Tennessee, on Friday, January 23, 1998, beginning at approximately 10:40 a.m., for all purposes allowed under the Federal Rules of Civil Procedure.

It is agreed that Carol A. Nichols, Registered Diplomate Reporter, Certified Shorthand Reporter, and Notary Public for the State of Tennessee at Large, may swear the witness, take the deposition, and afterwards reduce same to typewritten form, and that the reading and signing of the completed deposition by the witness is waived.

All formalities as to caption, certificate, transmission, filing, et cetera, are waived. All objections except as to the form of the questions are reserved to on or before the hearing.

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EXHIBITS

(None offered.)

[p. 3] *Frank Henry Boehm, M.D.*, having been duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. HELLER:

Q. Would you please state your name for the record?

A. Frank Henry Boehm.

Q. Have you ever had your deposition taken before?

A. Yes.

Q. So you're familiar with the process?

A. I am.

Q. How are you currently employed?

A. I am employed by Vanderbilt Medical Center.

Q. How long have you been with Vanderbilt?

A. 25 years.

Q. In what capacity are you employed by Vanderbilt?

A. I am Professor of Obstetrics and Gynecology in the medical school, and I am Director of Obstetrics for the hospital.

Q. Where are you licensed to practice medicine?

[p. 4] A. The state of Tennessee.

Q. And do you have any board certification?

A. I'm board certified in obstetrics and gynecology and in maternal-fetal medicine.

Q. Just this morning Mr. Smith gave me a copy of your curriculum vitae which has been marked as Trial Exhibit Number 23, and I just wanted to ask you if that's accurate and fairly current?

A. It is.

Q. Thank you. Have you given testimony before in court?

A. I have.

Q. On what occasions?

A. Since 1981, I have served as a medical-legal expert consultant and I have – I go to trial somewhere around three to four times a year.

Q. In what locations?

A. All over the country.

Q. Have you testified in federal court?

A. I have.

Q. Do you typically testify as an expert in those cases?

A. Yes.

Q. And is your testimony typically offered on behalf of a plaintiff or defendant or either?

[p. 5] A. Either. Most of it has been defense, but in trial I have – in the last four years I have been to trial fifteen times, two for the plaintiff and thirteen for the defense.

Q. Have you testified in any criminal cases?

A. No.

Q. Have you previously testified in a case involving the constitutionality of a state statute?

A. No.

Q. Have the cases you've testified in been primarily malpractice cases?

A. Yeah. 100 percent of them have been malpractice cases.

Q. Okay. How did you become involved in this case?

A. A phone call from Jim Smith's office in Nebraska asking whether I would be willing to serve as a consultant or to do a deposition or to testify on behalf of the State of Nebraska.

Q. And you agreed to do that; is that right?

A. I did, yes.

Q. Are you being paid a fee to testify?

A. No.

Q. You're doing this without charging any fee to the State of Nebraska; is that correct?

[p. 6] A. If I have to go to Nebraska to testify at trial, I would charge the State for my expenses, flight and hotel and food. But other than that, I'm not charging anything.

Q. Have you been approached by any other entities to testify either for or against the constitutionality of state statutes?

A. Yes.

Q. Can you tell me about that? In other words, who has approached you?

A. I have received phone calls from the Attorney General's office in the states of Alaska, Rhode Island, Arkansas, and Georgia.

Q. Have you agreed to testify in any of those cases?

A. I have.

Q. In which ones?

A. All of them.

Q. Have you submitted any written affidavits in any of those cases or written sworn statements?

A. I believe I have in one case, but I'd have to check my records. I can't remember which one, and I'm not even that sure that I did. My memory allows me to say to you I think I have in one case.

Q. And are those cases you mentioned, Alaska, [p. 7] Arkansas, Rhode Island, –

A. And Georgia.

Q. – and Georgia, are they all involving partial birth abortion statutes?

A. Exactly.

Q. Have you – are you charging a fee in any of those cases?

A. No.

Q. Is it a similar arrangement where if you had to go out to that state to testify, you'd ask for your expenses to be covered?

A. Yes.

Q. And you haven't ended up testifying so far in any of those cases?

A. This is my first.

Q. Prior to this deposition today, have you given testimony in a case involving abortion? In other words, were any of the malpractice cases involving abortion?

A. Yes.

Q. In what respect was an abortion involved in any of your prior testimony?

A. Well, I can only remember one case, and it was a wrongful death case where abortion was induced with an error in diagnosis. But it did involve [p. 8] abortion, but the issue was wrongful death rather than abortion.

Q. Do you recall what state that was in?

A. It was in the state of Alabama.

Q. And on what side were you testifying in that case?

A. For the defense of the doctor being accused of making a wrong diagnosis.

Q. I see. Have you published any articles about abortion?

A. Yes.

Q. Is it possible for you, looking at your CV, to identify any of those for me if you look through it?

A. The yes came more from published in a newspaper column that I have that I write for two newspapers in Nashville and in Florida.

Q. Okay.

A. That is published. But scientific publication, there may be one or two in here. Let me see. Yes. Paper number 47 entitled "Induced Abortion: A Risk Factor for Placenta Previa."

Q. Okay. Thank you.

A. Article 98 is entitled, "Wrongful Life and Wrongful Birth." I don't know if that addresses abortion. I haven't read it since 1989, but I'll [p. 9] mention it for completion's sake.

Q. Okay.

A. That's it.

Q. Okay. Thank you. Do you consider yourself an expert on the statistical safety of different abortion methods?

A. Sure.

Q. And have you, yourself, done research in that area?

A. No.

Q. Do you currently perform abortions in your medical practice?

A. Yes.

Q. How long have you been performing abortions?

A. Since my residency in the 1960's.

Q. Approximately how many abortions would you say you performed in the last year?

A. This is like a Dr. Henry Foster question.

Q. No.

A. Oh, Lord. I really don't know. It's not that many. The abortions that I do at Vanderbilt are usually second trimester abortions for congenital anomalies or serious problems that affect mother's health or well-being, most of them being anomalies. [p. 10] And I usually help the residents with these cases. Perhaps somewhere between a half a dozen to a dozen I've been involved in. But I really don't have an exact number.

Q. Would you say over the course of your career you've done more than 100 abortions?

A. Oh, sure.

Q. More than 1,000? I'm not trying to pin you down. I'm just trying to get a rough idea.

A. More than 1,000? Probably not more than 1,000.

Q. So somewhere in between 100 and 1,000?

A. That sounds reasonable.

Q. And what's the earliest in gestational age that you've done an abortion?

A. Oh, somewhere around six or eight weeks of pregnancy.

Q. And what would be the latest in gestational age?

A. 22 weeks.

Q. And when you say 22 weeks, do you mean from the woman's last menstrual period?

A. I do.

Q. At what point do you consider fetal viability to occur?

[p. 11] A. 24 weeks.

Q. Do you believe that 24 weeks is sort of a hard and fast rule or varies depending on the particular pregnancy?

A. No, I think it's a reasonably hard and fast rule.

Q. What abortion methods have you used during the past year?

A. During the past year I've used the prostaglandin-induced labor, induced abortion technique.

Q. Any other methods?

A. No.

Q. Have you ever used the dilation and evacuation abortion method?

A. D & E, I have.

Q. When was the last time you used that method?

A. Oh, maybe three years ago.

Q. And were you terminating a pregnancy where there was a live fetus at the beginning of the procedure?

A. I was assisting one of my partners with the evacuation of a live fetus, yes.

Q. During the course of your career, could you [p. 12] estimate out of the 100 to 1,000 abortions roughly what proportion were D & E's?

A. Small proportion, less than 5 percent.

Q. So if it's less than 5 percent, it's somewhere between 5 and 50 we could say?

A. That sounds about reasonable.

Q. And what proportion have been inductions using prostaglandin or other drugs or saline?

A. Ever since I started doing these?

Q. Yeah. Of the entire number you've done, how many have been by induction?

A. I would say 75 percent have been by induction and the other 25 have been first trimester abortions with the simple suction curettage or D & C.

Q. Have you performed abortions exclusively – let's say within the last 25 years, exclusively here at the hospital?

A. Yes.

Q. Do you recall writing an article for The Tennessean newspaper entitled "Doing the Right Thing for the Right Reasons"?

A. Yes.

Q. Is it your view that after viability in a case where the life or health of a mother is in jeopardy and her fetus has reached a reasonable chance [p. 13] of survival outside the womb that physicians can deliver the child by either cesarean section or induction of labor without compromising the mother?

A. Yes.

Q. Do I understand then that it's your view that a c-section doesn't compromise the woman's health as opposed to a D & E?

A. It depends on the relativity of the discussion. So if you bring it up, cesarean section versus D & E, the cesarean section would be more – would increase the risk of morbidity to the mother than the D & E.

Q. Also mortality; isn't that right?

A. Probably mortality. Although the numbers are small, there probably would be a slight increase in cesarean section over D & E. But those studies have never really been done to compare the two. But from background, training, and experience, I would agree with you that it would increase morbidity and mortality over D & E.

Q. And what would be the reason not to do a D & E after viability?

A. Well, that's 24 weeks. That's a very large fetus to be dismembering vaginally. Forgetting, the ethical principles and moral principles, putting that [p. 14] aside for a moment which I'm sure we'll get into, I don't know of anyone that performs D & E's at 24 weeks. That is an incredible experience. Even the most ardent advocates of D & E's stop somewhere around 18 weeks, perhaps 19 or 20 in a pinch so to speak. But I know of no one that would offer a D & E at 24 weeks.

Q. Let's assume for a moment that we're talking about a situation where there has been fetal demise at 26 weeks.

A. Right.

Q. Would you deliver the dead fetus by cesarean section?

A. Oh, no. That would then include either prostaglandin or D & E. When I said – my earlier comments on D & E was on a living fetus. But sometimes when a fetus has been dead for a while, it becomes emaciated and it's easier to remove vaginally. But even in those cases, we would use prostaglandin and not a D & E. The fetus is just too big at that stage to be taking it out piece by piece.

Q. And you're aware of no one in your profession who performs D & E's after 24 weeks?

A. Never heard it done, never seen anyone do it, never read about anyone doing it. While anything is possible in this country, I would never recommend [p. 15] such a procedure and have never seen anyone or heard of anyone doing that.

Q. And what about at 22 weeks? Have you heard of people doing D & E's at 22 weeks?

A. In dead fetuses, yes. But again up to 20 weeks has been as far as I've ever seen anyone advocate a D & E, and most of the people that I know that do them routinely stop somewhere around 18 weeks.

Q. Would that be different if you induced fetal demise by digoxin at 22 weeks? Would that change whether you should or shouldn't do a D & E?

A. Well, there are two reasons that a physician may not want to do a D & E. One is the procedure itself is somewhat aesthetically unpleasant, especially on a live fetus. So first performing a procedure that would result in fetal death, such as a cardiac injection of potassium chloride, would make that more palatable.

The other is the technique itself. It's not easy to dilate a cervix large enough to get a head through at that gestational age. But I don't think that I'm in a position to say that doctors have never done that or don't do that in this country. I'm just not aware of them.

Q. Of the two procedures, putting aside the [p. 16] c-section for a moment, let's say at 20 weeks or 19 weeks if you could do either a D & E with a live fetus or a prostaglandin-induced delivery, which would you say is more debilitating or disabling for the woman, which of those two procedures?

A. Well, the data indicates that it's morbidity-wise slightly safer for a D & E in experienced hands as opposed to prostaglandin. Having said that, I don't know of any side-by-side studies that prove that although I

don't argue with that. But at Vanderbilt for the last 25 years, we have used labor induction technology. And in the last few years the use of Cytotec, which is a prostaglandin product compound, is so effective that I would love to see some studies that compare Cytotec-induced abortions with D & E's to see if that safety factor still holds true.

Some of the older studies were done with intraamniotic saline and intraamniotic prostaglandin, and in those cases it was clear that the D & E was safer. But I don't know of any studies that compare the D & E at 18 weeks, 20 weeks let's say, with Cytotec or the prostaglandin gels that are now readily used for abortion.

So the older data would support your premise or the premise that D & E's might have less [p. 17] morbidity, but I don't know if that can still be said for the newer compounds.

Q. I just have a few more questions. What I was driving at was something slightly different. Let me approach it this way. How long a procedure is the prostaglandin induction procedure?

A. We tell patients it's approximately 24 hours.

Q. And during that 24 hours, what does the woman experience?

A. Contractions, cramps which we give epidurals for to reduce discomfort. They're in a labor bed. They have an intravenous going, running. We administer the prostaglandin intravaginally and wait for contractions, give them pain relief, and then they deliver usually within 24 hours the fetus and placenta and are sent home.

Q. And the D & E at 20 weeks, how long a procedure is that?

A. Well, we just don't do them at 20 weeks. But having seen them let's say at 16 weeks – I could speak from experience – that would be certainly the upper limit for any of us. You're talking about from admission to the hospital to the operating room, maybe an hour, and then in the operating room, perhaps an [p. 18] hour, and then recovery, a few hours.

So we're talking about, you know, maybe a six-hour admission to the hospital. But the procedure itself shouldn't be more than an hour.

Q. And can an induction procedure, the one you've described, can that be done outside a hospital?

A. Sure it can be, but we think it should be done within a hospital.

Q. What about a D & E? Can that be done outside a hospital?

A. It can be done in a clinic. Up to a certain gestational age, it's recommended to do it in a hospital, but it can be done in clinics and are in many instances done in clinics.

Q. Do you believe they're done fairly safely in clinics?

A. I think so, yes.

Q. Is it also fair to say then that the induction procedure at 20 weeks is going to be more expensive if it's done in a hospital as opposed to a D & E done in a clinic?

A. Yes, I would agree with that.

Q. And if you had a patient – and this is hypothetical, of course – who was 20 weeks pregnant and wanted to terminate the pregnancy, what would you [p. 19] advise her?

A. Well, what are the indications? Do I have an indication other than she doesn't want the pregnancy?

Q. She doesn't want the pregnancy.

A. I would advise her to continue the pregnancy and deliver the child and give it up for adoption. If that didn't work, then I would give her the names of physicians outside of Middle Tennessee because no one in the Middle Tennessee area would do such an abortion. And then she would have to go to another city or state or both.

Q. Do you know where, what place you would refer to?

A. We refer to Atlanta and to Louisville.

Q. Do you know what office or doctor in Atlanta you refer to?

A. No. We also would have recommended to Wichita, Kansas, and that would be Dr. George Tiller.

Q. Do you know in Georgia, is it the Midtown Hospital?

A. I believe that's the name of it.

Q. Do you know what procedure they use there? Do they use prostaglandin there?

A. The only technique I know about is Dr. [p. 20] Tiiler's. I don't know what they use in Atlanta, but it

could either be a D & E or some type of prostaglandin. I just don't know.

Q. Do you know how far in Atlanta, how far along in pregnancy they do D & E's?

A. No.

Q. Okay. Let's get back to the 20 weeks – the woman is 20 weeks. You've referred her somewhere. Would you tell her for one reason or another it's better to have a prostaglandin-induced termination or it's better to have a D & E, or would that be her choice?

A. Well, I mean if she asked me after I told her that I wouldn't do it and that there was no one in Nashville to do it and then she asked me which I would recommend, I would recommend the prostaglandin abortion rather than the D & E at 20 weeks.

Q. And what would be the basis for your recommendation?

A. Well, there are complications with both. There's no question about it. But there are fewer and fewer doctors who are really trained and are proficient at performing D and E's. It is a relatively unpalatable and unaesthetic, if those are the right words, procedure for the health care provider and those [p. 21] in the room to witness. The dismembering of a living fetus is not something to be taken lightly. The patient has to know what's going to happen, and frequently she and her significant other are not interested in a procedure that actually does that to her fetus, even though she doesn't want it. The prostaglandin technique allows for an intact delivery of a stillborn, that it may take a little longer, it may be more

expensive but doesn't have the negative connotations and doesn't include the risks of uterine perforations and significant hemorrhage that could lead to hysterectomies and has in some instances.

So I think all in all, while there are differences in morbidity and length of stay and costs, I still would recommend the prostaglandin over the D & E at 20 weeks.

Q. Can a prostaglandin induction occur when a fetus for some reason is not dead when it emerges?

A. Occasionally, a fetus at 20 weeks will be born alive. That is the heart will be beating. That is not common, but it has happened.

Q. And then can the baby survive?

A. No. Fetuses cannot survive until 23 weeks where there is a 15 percent survival rate, and that's [p. 22] why we stop at 22 weeks and 6 days at Vanderbilt.

Q. Have you ever – in the course of the procedures you've done that you indicated for some sort of fetal indication, have you ever had to decompress the head of a fetus in order to remove it?

A. Yes, I have.

Q. And what method do you use to decompress the head?

A. The procedures were though [sic] on term babies who had severe hydrocephalus, and in those cases we have used the ultrasound-guided cephalocentesis method where we drain the ventricles of the amniotic fluid to allow the head to slip through the cervix.

Q. If you saw a woman and the fetus had some sort of cranial deformity like hydrocephaly or anencephaly and the head was enlarged and she wanted to terminate the pregnancy because she believed it wasn't going to survive, the child wouldn't survive the birth, would there be any reason not to depress the skull in that situation in order to facilitate removal of the fetus?

A. Well, first of all, let's just differentiate between anencephaly and hydrocephaly. Anencephaly would never have a head so large it couldn't be delivered, and you wouldn't have to [p. 23] decompress the head because there is no brain. The top of the brain is gone, so that would never present itself with anencephaly.

But let's stay with anencephaly for a moment. If a woman came to us at 30 weeks of pregnancy or 26 weeks of pregnancy or anything beyond our normal abortion techniques of 22 weeks and 6 days and we knew that it was an anencephalic fetus, – that is it had a lethal anomaly; it could have other anomalies that would be lethal, but this would be one that we would classify as lethal – we would deliver the patient. We would induce labor, but we would not call that an abortion.

An abortion is a procedure done with the intent of delivering a dead fetus. Our intention is to deliver the fetus and if it is a lethal anomaly, it will die on its own. So we will induce that patient whenever she wants us to induce her, but we don't call it an abortion after 23 weeks. It's just an induction of labor.

Assuming we're correct in our diagnosis, then the child will die. If we're not sure that it's a lethal anomaly, then we don't offer an induction. So that then takes us to

the hydrocephalic fetus. Unless we're convinced that the hydrocephaly is so massive as [p. 24] to preclude life outside the mother's womb, regardless of the gestational age, we would only induce that labor if we were convinced that it was incompatible with life.

If we were not convinced and we used neurosurgeons to help us with this, we wouldn't offer it. But if we offered it, then we would induce the labor, and if we needed to, we would decompress the head with the cephalocentesis procedure that I mentioned to you. But our intent is not to cause death with that procedure. Our intent is to deliver the fetus which would die anyway once it was born.

Q. Tell me again some of the – the last case you're describing, exactly what instrument would you use to decompress the head?

A. We use a needle, spinal needle that's either put suprapubically or through the vagina, – usually suprapubically with a breech – and under ultrasound guidance, place the needle into the dilated ventricle and allow the fluid to be drained off.

Q. Now when you say dilated ventricle, being not a doctor, I'm thinking the heart. Can you explain what that is?

A. Sure. There are ventricles in the brain, one on the left and one on the right, that drain [p. 25] cerebral spinal fluid. And when there's a blockage, it gets backed up and causes the enlarged head, the water head babies that you've heard about. And what dilates are the ventricles

in the brain. So we put a needle into the ventricles to drain the fluid only.

We don't try to aspirate intracranial cerebral matter or brain matter. Our intention is to allow safe passage of the fetal head through the cervical canal.

Q. I might just have one or two more questions. I take it you favor the statute at issue in this case?

A. Oh, yes.

Q. And do you favor the punishment that's provided in it? Do you know what the punishment is?

A. Anywhere from what, one to twenty years in jail?

Q. Mm-hmm.

A. No. I don't favor the punishment. On the other hand, that is not my expertise. I would rather not have to have a ban on partial birth abortion because I would rather doctors be more conscientious and not offer this to women. But having said that, knowing that there are doctors who are supportive of partial birth abortion, and understanding the [p. 26] reasoning for the ban created by various state legislatures as well as our own federal government, despite the veto, I also understand that punishment has to be attached.

And this is not an area that I consider myself an expert in, but I have an opinion that I wish that we didn't have to have a felony statute with this. But it's the real world, and I accept it for reasons that we'll probably get into later.

Q. Yeah, just – and is your opposition to what you understand to be partial birth abortion based on the belief that the procedure is dangerous for women?

A. No.

Q. Is it then based on your belief that it is – well, let me see if I can –

A. I can tell you.

Q. Well, do you recall writing – excuse me. I shouldn't say writing. Do you recall saying to a reporter at the Nashville Banner something to the effect that this is a bad procedure, it's pretty gruesome, people are disgusted that doctors are even doing it?

A. Yes.

Q. So what I understand from that – tell me [p. 27] if this is right – is that you believe that it's a gruesome procedure, it's one that's needlessly harmful to a fetus and needlessly disrespectful of a fetus in some way?

A. That's one reason.

Q. What are the other reasons?

A. The other reason is it's not needed. There are safe alternatives. How safe compared to other procedures is something that we really don't know because no one has ever done any research on partial birth abortion and compared it to other procedures. So the argument that partial birth abortion described by the American College of Ob/Gyn in January of 1997 is safer has never been proven.

So it's all theory. So I think it's easy to come to the conclusion for me – and obviously many others, but certainly I'll speak for myself – that there are safe alternatives that have set some moral and ethical guidelines and works within a framework that I think is healthy for – more mentally healthy for the health care providers as well as for the patient.

So my reason is it's not needed and it is morally and ethically – it goes beyond the line that I think most of us in medicine draw between what is [p. 28] morally and ethically accepted and what is not. The two together allow me to be then supportive of a ban, even if attached to that are punishments.

Q. You mentioned there has been no study showing that this what you understand to be a partial birth abortion is safer. You would concede, wouldn't you, that if you ban the procedure, there will never be such a study?

A. Well, that will be fine with me. Sure, I understand that. You have to understand that partial birth abortion is a term that just came onto the horizon officially January of 1997. It never was in any of our textbooks in obstetrics. We were never taught it. I was never taught it. I've never seen one.

The first time I even heard of a partial birth abortion was when it was announced on the floor of the senate with posters showing the procedure. Even the term "late term abortion" has no medical meaning. It doesn't have any description in any of the literature. So this is something that some doctors have done for a variety of reasons. And we now in the medical community are being asked to comment on it so that that's what I'm doing.

Q. I understand. And don't you think such a [p. 29] ban would stifle potential advances in making abortion procedures safer for women?

A. Well, I don't think that I would call these advances.

Q. Oh, I'm sorry. I didn't say that they were advances, potential advances.

A. Well, if you have to cross an ethical line, then I don't think that even if you could prove that it may have some medical advantage that it should be used. And you have a point that if you ban a procedure, you can't do research on it. However, if the ban is well intentioned based on not only medical but in essence moral and ethical grounds, then I think you're duty bound to not even do research.

Medical research has been done on a lot of individuals and has crossed that line, and nobody I know would support the medical research that either occurred in Germany or occurs in Iraq and other places that we hear about. The fact that maybe some of that research might have brought some good to humankind later doesn't justify or rationalize the use of that research technique to find out.

So because we have safe alternatives, very safe alternatives, I think those of us who are, – speak for obstetrics, those of us who care about what people [p. 30] think, of those of us who have to do abortions in this world, I think we have a moral obligation to set certain limits and guidelines. And that's what we have done here at Vanderbilt, and that's what I continue to want to do. So I can

speak against a procedure even though many of my colleagues in Washington, for example, disagree with me.

Q. If someone found – some majority in Tennessee found that prostaglandin-induced abortions were morally offensive and banned them because there were safe alternatives, – the D & E, the partial birth procedure as you understand it – would you accept that?

A. Well, morally acceptable is obviously in the eye of the beholder so to speak, and you raise a very interesting question. If partial birth abortion is ethically and morally improper in my opinion, why not the D & E and the prostaglandin technique?

And I would agree with you if it was done beyond the stage of viability. But if it's done prior to viability, then I think these are procedures that while they would be condemned by individuals who are pro-life, I think that the fact that they are safe, that there is a need under this kind of gestational age limits that I wouldn't find it morally or ethically [p. 31] offensive.

Q. And then in terms of the partial birth procedure you're talking about, how do you define that?

A. Well, I define it as the American College defined it. There were four criteria: Intentional dilatation of the cervix, converting a fetus to a breech, extracting to the head, and then evacuating the intracranial contents. That is the American College of Ob/Gyn's definition. The definition that has surfaced in Nebraska as well as Tennessee is different.

Q. But you believe covers the exact same procedure?

A. Well, I'm not wild about the wording, and I would love to have had the American College of Ob/Gyn's definition used, but I understand the reasons or I believe I understand the reasons why it was not. But I think it is specific enough to include the American College of Ob/Gyn's definition.

Q. For example, does it include anything about conversion of the fetus?

A. No.

Q. So it doesn't match in that respect?

A. No. Actually one and two, the first two definitions really are not very important to the procedure because if the fetus is already breech, then [p. 32] the doctor wouldn't have to convert. But the third and fourth definitions, – that is delivery to the fetal head and then evacuation of the intracranial contents – I think those two are covered by the statute that Nebraska and Tennessee have written into their law.

Q. What was the first of those two that you think is covered again, please?

A. Delivery of the fetus to its neck.

Q. Where do you see that? How do you get that in the Nebraska statute?

A. Oh, not in the Nebraska. In the American College of Ob/Gyn.

Q. But is it in the Nebraska statute?

A. No, but I think the Nebraska statute is specific enough to include either the four or the two definitions that I just described from the college.

Q. I'm sorry. This will hopefully cut down on my eventual cross-examination.

A. Okay.

Q. You indicated that you had observed or assisted in a D & E within the last –

A. Three or four years.

Q. When was the last time you actually performed one, yourself?

[p. 33] A. Maybe ten years.

Q. Now in a D & E, can you sometimes reach into the uterus with forceps, remove let's say a hand?

A. Yes.

Q. Can the fetus still be alive?

A. Yes.

Q. Is a hand a substantial portion of the fetus?

A. That will eventually obviously be the pivotal point if it ever gets to someone trying to push the issue for definition. In my opinion the word "substantial" does not include a hand.

Q. And what's your basis?

A. Well, substantial means a significant portion.I think a significant portion is not a hand.

Q. Would it be a leg?

A. No. I think you'd have to bring in a reasonably large portion of the fetus through the birth canal. And I'm not sure that I can define that, but I don't think anyone has or could. So I think that's where some people have been concerned.

I feel substantial portion means a significant portion of the fetus. And while I could say greater than half of the body, that would be my own personal view and not necessarily the view of someone [p. 34] who wants to prosecute this letter of the law.

Q. So you would agree that some people might view removal of a hand as a substantial portion. Certainly if –

A. Well, in this country I suppose anything could be said. But I think that the average jury would not believe a hand to be a substantial portion. Having said that, I hope it's never tested. But the easiest way to get around this whole thing is for doctors to stop doing this procedure.

Q. I understand. But if it did cover – if a hand did constitute a substantial portion or a leg, you would agree the statute could cover D & E's?

A. If that were deemed a legal definition then, of course, it would include D & E's.

Q. Have you seen any legal definition more carefully defining "substantial portion" than Nebraska law?

A. No, I haven't. The other states, for example, that don't have this added definition that the AMA's bill or rule allowed, which is what Nebraska copied or used as

their definition, without that particular wording – that is delivering a living fetus into the vagina or a substantial portion – without that, then D & E's would be included, any D & E [p. 35] would be included in the definition.

Q. Why is that?

A. Because I think if you don't have the word "substantial", then a hand or a foot would be considered under the definition as the states have written them.

MR. HELLER: Thank you.

(Deposition ended at 11:24 a.m.)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 33

Nebraska State Legislature
[LOGO]
Ninety-Fifth Legislature

[Names And Addresses Omitted In Printing]

MEMORANDUM

To: Co-Sponsors of LB 23

From: Senator David I. Maurstad

Date: April 10, 1997

Re: Preliminary Information on Partial-Birth Abortion

As we work down the list of Senator Priority Bills on general file, LB 23 has moved closer to the top of the agenda. After consulting with the Speaker's Office it is difficult to determine how soon the bill will be addressed. However, should LB 23 be debated in the near future, I wanted you and other co-sponsors to have some preliminary information about the issue.

I also want to take this opportunity to make a personal plea for your presence on the floor during discussion of this bill. Your presence and support would be appreciated, especially on key votes.

Attached is material prepared by my office in cooperation with Julie Schmit-Albin and Jim Cunningham. We have attempted to address questions that have been raised

about the partial-birth abortion issue. I will have additional information which will be distributed on the floor when the bill is taken up.

If you have any questions about LB 23 or the partial-birth abortion issue, please do not hesitate to let me know. I will do my best to provide you with whatever information you need.

PARTIAL BIRTH ABORTION: A FACT SHEET

What is a Partial-Birth Abortion and What Would LB 23 Do?

- LB 23, as amended by committee amendment (AM0748), defines partial-birth abortion as an "abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery."
- LB 23 would prohibit performance of any partial birth abortion, except in cases (if there are any) in which the procedure is necessary to save the life of a mother and no other procedure would suffice.
- Abortionists who violate the law would be subject to both criminal and civil penalties, but no penalty could be applied to the woman who obtained such an abortion.

Are the Drawings and Descriptions Accurate?

YES, absolutely! The drawings and descriptions of the partial-birth abortion procedure (see attachment #1) are based upon a 1992 paper presented to the National Abortion Federation by Ohio Abortionist Martin Haskell in which he described in detail, step-by-step, how to perform the procedure. Dr. Haskell has acknowledged

that these drawings are "technically accurate." (*American Medical News*, 7/5/93) The following description came from his paper:

- "With a lower [fetal] extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities. The skull lodges at the internal cervical os [the opening to the uterus]. Usually there is not enough dilation for it to pass through. The fetus is oriented dorsum or spine up. At this point, the right-handed surgeon slides the fingers of the left hand along the back of the fetus and "hooks" the shoulders of the fetus with the index and ring fingers (palm down) . . . [T]he surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger . . . [T]he surgeon then forces the scissors into the base of the skull or into the formen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening. The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents."

Partial-Birth, D & X, Intact D & E – Which Term Should Be Used?

- There is no consensus even among abortion practitioners, about what to call this procedure. One doctor calls it "dilation and extraction" ("D & X"), and another "intact dilation and evacuation" ("intact D & E"). When the Partial-Birth Abortion Ban Act was written in 1995, neither "D & X" nor "intact D & E" appeared in any medical dictionary or in the Medline medical database. Nor did either term appear in the

textbook on abortion methods, *Abortion Practice*, by late-term abortion specialist Dr. Warren Hern.

- Thus, these terms ("D&X", "Intact D&E") originated as a kind of pseudo-medical jargon which should not be employed in a criminal law because of the risk that the courts will declare that law to be "void for vagueness." "Partial-birth abortion" was chosen to satisfy the requirement that criminal laws must be precisely descriptive of what is forbidden in order to pass constitutional muster.

Why are Partial-Birth Abortions Performed?

- *The overwhelming majority of partial-birth abortions are performed for purely non-medical reasons.*
- Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers, while admitting to lying previously about this, confirmed in the March 3, 1997 *American Medical News*, that in the vast majority of cases the procedure is performed on a healthy mother with a healthy fetus of 20 weeks or more gestation.
- On September 15, the Bergen, N.J. *Record* published a report by staff writer Ruth Padawer in which two abortionists at an abortion facility in Engelwood, N.J. admitted performing over 1,500 partial-birth abortions. The following are the reasons they stated for performing these procedures:

"We have an occasional amnio abnormality, but it's a minuscule amount." Most are Medicaid patients, black and white, and most are for elective, not medical, reasons: people who didn't realize, or didn't care, how far along they were. Most are teenagers."

- The September 17, 1996 edition of the *Washington Post* contained the results of an investigation conducted by

reporters Barbara Vobejda and David Brown, M.D., who interviewed several doctors (*not* those in New Jersey), and concluded:

"Furthermore, in most cases where the procedure is used, the physical health of the woman whose pregnancy is being terminated is not in jeopardy . . . Instead, the "typical" patients tend to be young, low-income women, often poorly educated or naive, whose reasons for waiting so long to end their pregnancies are rarely medical."

- In a taped interview for the American Medical Association's *American Medical News* (July 5, 1993), Dr. Martin Haskell said of partial-birth abortions he performs:

"And I'll be quite frank: most of my abortions are elective in that 20-24 week range . . . In my particular case, probably 20% are for genetic reasons. And the other 80% are purely elective."

- Before his death in 1995, Dr. James McMahon voluntarily submitted to the House Judiciary Subcommittee on the Constitution a self-selected sample of more than 2000 partial-birth abortions he performed and the reason for each.

Only 175 of these procedures were done for "maternal indications," the most common of which was "depression." 1,183 cases (about 56%) were for "fetal flaws," but these included a great many non-lethal disorders such as cleft palate and Down Syndrome. More than one-third of these 2000 cases did not involve either fetal or maternal health problems, however trivial.

- In an op ed piece written for the *Los Angeles Times*, Dr. Katherine Dowling, a family physician at the University of Southern California School of Medicine, examined Dr. McMahon's report on this "fetal flaws"

group. She concluded that "most of the partial-birth abortions in that [McMahon] survey were done for problems that were either surgically correctable or would result in some degree of neurologic or mental impairment, but would not harm the mother. Or they were done for reasons that were pretty skimpy: depression, chicken pox, diabetes, vomiting."

At What Stage of Pregnancy Are Partial-Birth Abortions Performed?

- Apparently, **most partial-birth abortions are performed late in the second trimester, between 16 and 24 weeks' gestation.** However, **some are performed in the third trimester** and not only for cases of extreme physical disorders of the mother and/or baby as claimed by abortion advocates.
- In 1995, the late Dr. James McMahon submitted to the House Judiciary Subcommittee on the Constitution a graph and explanation that explicitly showed that **he aborted *healthy* ("not flawed") babies** *even in the third trimester (after 26 weeks of pregnancy)*. Dr. McMahon's own graph showed, for example, that at 29 or 30 weeks, *one-fourth* of the aborted babies had no "flaw" however slight.

How Many Partial-Birth Abortions are Performed?

- Partial-birth abortions occur at least several thousand times a year in the United States. Just one New Jersey facility reported performing about 1500 each year. Ron Fitzsimmons from the National Coalition of Abortion Providers, recently publicly acknowledged that there are **as many as 5000 per year in the United States.**
- **Leroy Carhart, a Bellevue abortionist, admitted in an *American Medical News* article (10/7/96) to performing 1000 "intact D and E's" in the last two years.**

Partial-Birth Abortions – Nebraska Connection

According to an October 7, 1996 *American Medical News* article, Leroy Carhart, a Bellevue abortionist, "has done about 5000 intact D & E's [dilation and evacuation/partial-birth abortions] and 500 in the last year." Diane Gianelli, who wrote the article, sent a copy of it to Carhart after it was printed and received no response regarding its accuracy.

In a subsequent *AM News* article regarding the Ron Fitzsimmons' lie, Gianelli again mentioned Carhart's admission to doing "about 5000 intact D & E's, about a 1000 during the past two years". Then, in the February 28, 1997 *Omaha World Herald*, Carhart claims that the *AM News* article was inaccurate and that what he meant to say was that he had performed about 5000 abortions in 1994 and 1995, of which 1000 were second trimester and about 50 to 100 were by "intact D & E".

Diane Gianelli, who conducted and taped the interview, contacted Carhart and played to him the tape of the interview. Since the tape makes it quite clear that Carhart performed 1000 "intact D & E's" in the last two years, he then acknowledged that the original article was accurate, but now says what he meant to say was that he performed 1000 late term abortions in the last two years in which he attempted to use the "intact D & E" (partial-birth abortion) method. However, he claims, the babies fell apart as he tried to pull them from the womb causing him to complete the abortion with a different procedure. Carhart says he kills the child with a lethal injection prior to performing the partial-birth abortion procedure.

[See Attachment #2 for related articles/documents on Leroy Carhart]

MOTHER'S HEALTH AND FUTURE FERTILITY ARGUMENT A FALLACY

Opponents of a ban on partial-birth abortions rely most heavily upon the widely publicized accounts of a few women whose doctor (the late James McMahon) told them that their children were gravely ill and that a partial-birth abortion was necessary to preserve their health or future fertility.

- **Nearly 500 doctors (more than 50 from Nebraska), mostly obstetricians/gynecologists and fetal/maternal experts, under the banner of the Physicians' Ad-Hoc Coalition for Truth, along with former Surgeon General Koop have publicly verified that *there are no medical conditions*, either maternal or fetal, that necessitate the use of partial-birth abortion in order to preserve the mother's health or future fertility. (See attachment # 3 for a list of Nebraska members of PHACT)**

Pamela Smith, M.D., Ob/Gyn, currently Director of Medical Education in the Department of Obstetrics and Gynecology at Mt. Sinai Hospital in Chicago; an Assistant Professor at the Finch University/Chicago Medical School; and a member of the American College of Obstetricians and Gynecologists, stated in testimony before the U.S. Senate Judiciary Committee on November 17, 1995:

- **"In short, there are absolutely no obstetrical situations encountered in this country which require a partially delivered human fetus to be destroyed to preserve the life or health of the mother."**

Curtis R. Cook, M.D., Maternal Fetal Medicine, Butterworth Hospital, Michigan State College of Human Medicine, stated in testimony before a March 11, 1997 House/Senate committee hearing:

- **"There is no record of these procedures in any medical text, journals, or on-line medical services. There is no known quality assurance, credentialling, or other standard assessment usually associated with newly-described surgical techniques. Neither the Centers for Disease Control nor the Alan Guttmacher Institute have any data on partial-birth abortion, and certainly no basis upon which to state the claim that [partial-birth abortion] is safer or even a preferred procedure."**

Even Some Abortionists Challenge the Medical Necessity Claim

In testimony in an Ohio lawsuit concerning the banning of partial-birth abortions, Dr. Harlan Giles, who performs second trimester abortions up to the point of viability, testified:

- **"I do not think there are any maternal conditions that I'm aware of that mandate ending the pregnancy that, also, require that the fetus be dead or that the fetal life be terminated. In my experience for twenty years, one can deliver these fetuses either vaginally or by caesarean section for that matter depending on the choice of the parent . . . And I cannot think of a fetal condition or malformation, no matter how severe, that actually cases [sic] harm or risk to the mother of continuing the pregnancy." (*Woman's Medical Professional Corp. v. Voinovich*, No.C-3-95-414, U.S. District Court, Southern District, Ohio (1995)).**

Dr. Warren Hern, a late-term abortion specialist who wrote a textbook on abortion methods, *Abortion Practice*, said in an 11/20/95 article in the *American Medical News:*

- **"I would dispute any claim that this [partial-birth abortion] is the safest procedure to use."**

Partial-Birth Abortion Poses a Threat to Women's Health and Fertility

Paul Hayes, M.D., a practicing Ob/Gyn in Lincoln and fellow in the American College of Obstetricians and Gynecologists, stated in testimony before the Legislature's Judiciary Committee (2/12/97):

- **"I think it's important to realize what this procedure asks of us as doctors to do . . . possibly as many as three very, very risky procedures. One is the dilation of the cervix itself manually before it is time for that to occur on its own and that runs a woman's risk up for preterm labor in the future. Also the instrumentation, putting sharp instruments into a woman's uterus blindly runs the risk of uterine perforation. And the very procedure of reaching into a woman's uterus, turning the baby from a head first position to a feet first position is literally prescribed against by my college of obstetricians and gynecologists, is forbidden by the *Williams Obstetrics and Gynecology* textbook as being entirely too risky for many different medical complications that occur . . . "**

So Who's Right About Partial-Birth Abortion's Impact on Woman's Health?

- *Look at the evidence*!!! Nationally, nearly 500 obstetricians/gynecologists, fetal-maternal medicine specialists, family practitioners, pediatricians, and other physicians (including former U.S. surgeon general C. Everett Koop, professors and hospital department heads) have publicly verified that partial-birth abortion is never medically indicated nor preferable, and, is itself a risk to the woman's life, health, and future fertility.

- We know of only one doctor nationally *not* affiliated with the abortion industry who has publicly defended the procedure as preferable to other late-term methods. It is likewise instructive that no physician testified in opposition to LB 23 at the public hearing held by the Judiciary Committee. Conversely, two physicians who specialize in obstetrics and gynecology, and who have significant experience treating pregnant women with difficult pregnancies like those used to defend partial-birth abortion, testified that this procedure is *never* necessary to preserve a mother's health or future fertility and, in fact, is quite dangerous to the mother.

- Even the American College of Obstetricians and Gynecologists (ACOG), a pro-abortion organization, has issued this statement: "A select panel convened by ACOG could identify no circumstances under which *this* procedure would be the only option to save the life or preserve the health of the women." Then citing neither specifics nor documentation, ACOG added that the procedure "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor . . . can make this decision." Members of PHACT, many of whom are members of ACOG, noted that ACOG had violated its own standards by approving a procedure for which there exists no peer-reviewed or safety data.

- In an interview with *American Medical News*, ACOG President, Frederic D. Frigoletto, M.D., backed away from the published statement. He claimed that ACOG

had not endorsed the procedure, and admitted that "there are no data to say that one of the procedures is safer than the other." It may be the best in some cases, he said, *"or it may not be."*

- The AMA Legislative Council unanimously rejected partial-birth abortion, saying it is "basically repulsive" and the AMA thereupon took no position on the proposed ban.

Why Use This Method?

In a partial-birth abortion, the abortionist dilates a woman's cervix for three days, until it is open enough to deliver the entire baby breech, except for the head.

- In a taped interview with *American Medical News* (July 5, 1993) Dr. Martin Haskell conceded that with a little further dilation, the **"fetus could just fall out. But that's not really the point. The point here is you're attempting to do an abortion. And that's the goal of your work, is to complete an abortion. Not to see how do I manipulate the situation so that I get a live birth instead."**

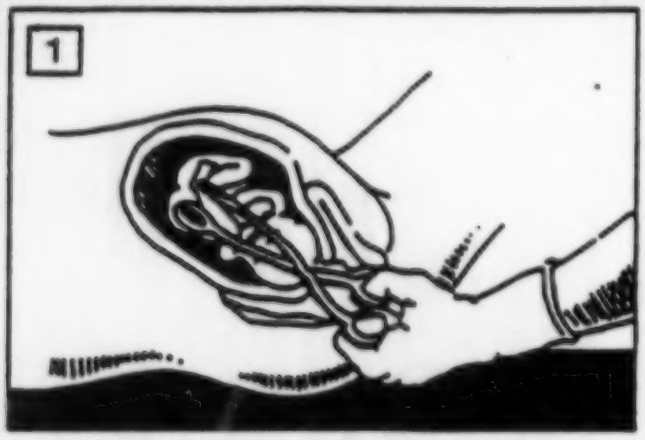
Is a Ban on Partial-Birth Abortion Constitutional?

- *Roe v. Wade,* which defined an expansive "right" to abortion, explicitly stated that its ruling did not apply to the killing of a child in the process of being born. [attachment #4] The partial-birth procedure is essentially the same as the procedure for inducing a breech birth, except that the child is killed when already mostly delivered. Even pro-abortion legal experts like Lawrence Tribe of Harvard University have said that the Supreme Court might uphold a ban on this kind of infanticide.

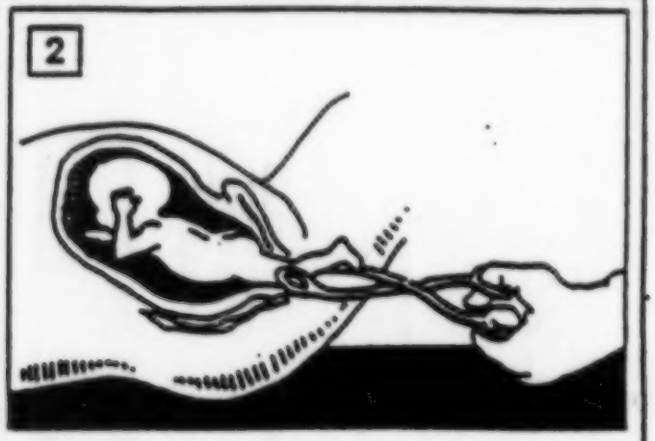
- In Nebraska, Attorney General Don Stenberg issued an official opinion in May 1996 concluding that a ban on partial-birth abortion could withstand constitutional challenge if enacted by the Nebraska Legislature. [attachment #5]

ATTACHMENT #1

PARTIAL-BIRTH ABORTION

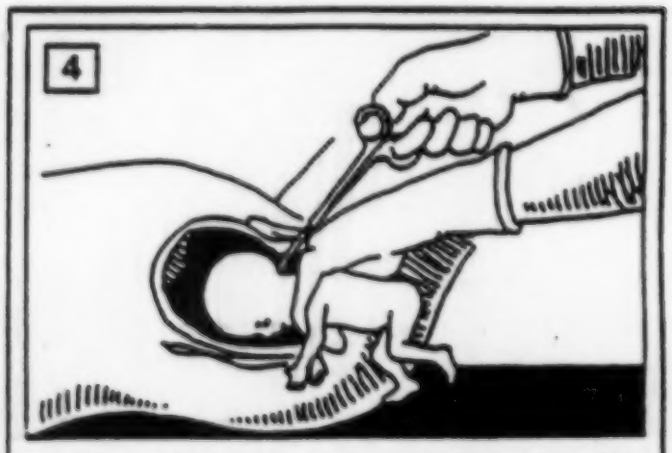


Guided by ultrasound, the abortionist grabs the baby's leg with forceps.

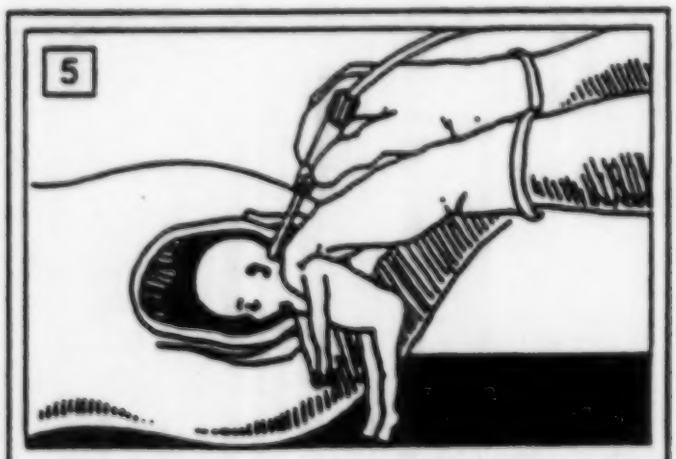


The baby's leg is pulled out into the birth canal.

The abortionist delivers the baby's entire body, except for the head.



The abortionist jams scissors into the baby's skull. The scissors are then opened to enlarge the hole.



The scissors are removed and a suction catheter is inserted. The child's brains are sucked out, causing the skull to collapse. The dead baby is then removed.

Judiciary Committee Memorandum
April 11, 1997

Proponents and opponents look at different aspects of constitutional abortion law in determining the constitutionality of partial-birth abortion statutes.

ARGUMENTS FOR CONSTITUTIONALITY

1. It can be argued that a child that is **partially born** obtains constitutional "person-hood" upon emerging from the birth canal even if not yet fully delivered and therefore the state has a constitutionally valid interest in preventing the killing of such child, which, under the definition, does not take place until **after** the child is partially delivered.

   The U.S. Supreme Court has not directly ruled on this issue, but **some weight** can be given the fact that *Roe v. Wade* did not challenge a provision in the Texas criminal code that made it a crime to kill a child "in a state of being born and before actual birth." Such statute remains on the books in Texas.

   The Supreme Court in *Roe* simply mentions that such section is the only section in the code chapter on abortion that is not being challenged as unconstitutional in that case. It is a **stretch** to state, as the House Judiciary Committee does, that such footnote "distinguishes between a child who is 'unborn' and 'being born.' "

   All that can be said for certain is that *Roe* did not strike down that particular section of the Texas criminal code, but, since it was not challenged, it would have been overreaching for the Court to do so.

Accordingly, this argument is **rather speculative** at this juncture. It certainly has merit, but there is no specific Supreme Court precedent upon which to rely.

To support the constitutionality of LB 23, the following argument would have to be upheld by the court: the state has a valid interest in protecting the life of a partially born child that is greater than its interest in protecting the life of a completely unborn child; therefore, the state may enact restrictions that protect the life of the **partially born child** after viability **without an exception as to the preservation of the health of the mother** and may enact restrictions that protect the life of the partially born child before viability even though such restrictions place an **undue burden** on the mother's right to an abortion.

2. The second argument is based on *Planned Parenthood v. Casey*, the most recent Supreme Court abortion decision. It contends that, even if the Court does not recognize a different constitutional status for the partially born, the banning of **partial-birth** procedures does not impose an **"undue burden"** on the right to choose an abortion.

   Under *Casey*, the state can act to "regulate" abortion **at any stage of a pregnancy** so long as the regulation does not place an **"undue burden"** on the right to choose an abortion. Accordingly, if a regulation does not place an undue burden on the abortion right, there is no need to consider whether the baby is "viable" nor whether there must be a "health" exception. (Regulations that do place an undue burden on the right can only apply after viability and still must contain exceptions for the "preservation of the life or health of the mother.")

   The validity of the "no undue burden" argument depends on the **factual determination** as to the use of partial-birth procedures.

I believe that this burden can be met, but a factual record needs to be made in accordance with the following:

- The purpose of the bill is to ban **one particular type of technique** (I call it a "type of technique" because the doctors who use the technique describe it by differing names and may use different means; the definition describes particular steps that are entailed in a "partial-birth" abortion) of accomplishing abortion.
- That particular type of technique, unlike alternatives, is particularly **akin to** acts that are **already criminalized**, is particularly contrary to state's legitimate and already expressed interest in the **protection of life** and is particularly shocking to the community's **sense of acceptable behavior**.
- The intent of the bill is **not to prohibit** any alternative techniques of accomplishing abortion.
- The effect of the bill is to **allow all other abortion techniques** to continue uninterrupted.
- The right to abortion **existed and was not unduly burdened** before the partial-birth type of technique was developed (it is not entirely clear when Dr. Haskell started using his version of partial-birth technique, but it was sometime between 1979 and 1992; *Roe* was decided in 1974).
- The right to abortion **exists and is not unduly burdened** in areas where doctors do not employ partial-birth type techniques (it is generally acknowledged that not all abortionists use such).
- The doctors who developed partial-birth techniques **did not develop such** in order to **protect the health or life** of their patients. Dr. Haskell frankly stated that he developed the technique

because it was **faster** and **less expensive** than alternative techniques (and, by allowing him to perform more late-term abortions, allowed him to make more money).

- The **tremendous weight** of **reliable medical opinion** is that partial-birth techniques are **never the only safe technique available** and **never medically necessary to save the life or health of the mother.**

Accordingly, I believe that a factual case can be made that "no substantial obstacle" is placed before a woman's right to choose an abortion by the banning of partial-birth type techniques. There would never be a case in which an abortion could not be performed.

ARGUMENTS AGAINST CONSTITUTIONALITY

1. Opponents argue first that a partial-birth abortion ban would be **unconstitutionally vague** regardless of its status under constitutional abortion law. When imposing a criminal sanction, the Legislature has a constitutional duty to clearly inform the public what acts are prohibited.

   Opponents contend that because the definition refers to "partial-birth abortion" and not a medically recognized term, that a doctor is not informed as to the exact technique that is criminalized.

   In response, it is evident from the medical literature that there are **a number** of terms that are used to describe techniques involving partial birth and that **none** is a universally acknowledged term.

   Instead, "partial-birth" is a **descriptive term** that covers **any technique**, regardless of the name used by the

given doctor, that involves the elements described in the bill.

I agree that a different term would be appropriate, such as "abortions involving the partial delivery of a living child." Right to Life insists on the term "partial-birth." Nonetheless, I think the elements of the offense are very clear and not vague:

- Partial vaginal delivery of a living unborn child.
- Killing the child; and
- Completing the delivery.

2. Opponents also point to the lack of a **health exception**. Clearly, under *Casey*, any prohibition of abortion can only apply (1) after viability and (2) contain a life and health of the mother exception.

   Since LB 23 applies to both pre- and post-viability abortions, the issue of a health exception is **irrelevant** because **any** restriction that places an "undue burden" on the abortion choice prior to viability is unconstitutional (whether it has a health exception or not) and any restriction that **does not** place an "undue burden" is constitutional **both before and after viability** (again, regardless of whether it has a health exception).

   Opponents confuse the prohibition of **abortion** (period) and prohibition of a **type of abortion**.

   - Clearly, the state cannot prevent a woman from **having an abortion** until after viability and only if it allows life and health exceptions.
   - If the state intends to prohibit a woman from **having a particular type of abortion**, then it must be determined whether the purpose or effect is to place an undue burden on the abortion right.

- If it **does** place an undue burden, then it cannot be imposed **prior to viability.**
- If it **does** place an undue burden, then it can be imposed **after viability** but only with life and health **exceptions**.
- If it **does not** place an undue burden, then it can be imposed before or after viability and with or without life and health exceptions.

If LB 23 were relying on the post-viability aspects of *Casey*, then it could only apply after viability and would have to include a health exception. Since LB 23 by its terms does **not** only apply after viability, its constitutionality **cannot** rely on the post-viability language of *Casey*. Therefore, it **must** base its constitutionality on the "undue burden" language of *Casey* **or** the argument that a partially born child has a different constitutional status than a completely unborn one.

The only way, then, that a health exception would be relevant to the legal analysis is if it were relevant to the "undue burden" determination. That is, theoretically, a regulation could constitute an "undue burden" if it lacks a health exception and not constitute an "undue burden" if it has a health exception. However, **if LB 23 does not constitute an "undue burden" as written,** then a health exception is irrelevant.

Feb 28 2000

(15)

No. 99-830

Supreme Court, U.S.
FILED
FEB 28 2000
CLERK

In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF OF PETITIONERS

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QUESTIONS PRESENTED

I. Whether the Eighth Circuit's adoption of a broad unconstitutional reading of Nebraska's ban on partial-birth abortion, which directly conflicts with the narrower constitutional construction of similar statutes by the Seventh Circuit Court of Appeals and that of the state officials charged with enforcement of the statute, violates fundamental rules of statutory construction and basic principles of federalism in contradiction of the clear precedent of this Court?

II. Whether the Eighth Circuit misapplied this Court's instructions in ***Planned Parenthood v. Casey*** by finding that a law banning a rare and controversial method of killing a partially-born child, is an "undue burden" on the right to abortion?

LIST OF PARTIES

The Petitioners are Don Stenberg, Attorney General of the State of Nebraska; Gina Dunning, Director of Regulation and Licensure of the Nebraska Department of Health and Human Services; and Charles Andrews, M.D., Chief Medical Officer of the State of Nebraska. An additional Appellant/Defendant below was Mike Munch, Sarpy County Attorney.

The Respondent is LeRoy H. Carhart, M.D.

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit is reported at 192 F.3d 1142 (8th Cir. 1999) (Pet.App.1).[1] The opinions of the United States District Court for the District of Nebraska in this case are reported at 972 F. Supp. 507 (D.Neb. 1997) (Supp.App. 91) and 11 F. Supp.2d 1099 (D.Neb. 1998) (Supp.App.1).

JURISDICTION

The judgment of the United States Court of Appeals for the Eighth Circuit was entered on September 24, 1999. A Petition For Writ of Certiorari was filed on November 15, 1999. Certiorari was granted on January 14, 2000. Jurisdiction in this Court exists under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

I. Neb. Rev. Stat. § 28-326(9):

> Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. For purposes of this subdivision, the term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living

---

[1] References to the Appendix to the Petition For Writ of Certiorari will be noted as "Pet.App. ___." References to the Supplemental Appendix to the Petition For Writ of Certiorari will be noted as "Supp.App. ___." References to the Joint Appendix will be noted as "J.A. ___." References to the Record Transcript will be noted as "R.Tr. ___." References to non-transcript portions of the Eighth Circuit Appendix will be noted as "Eighth Cir. App. ___."

unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.

II. Neb. Rev. Stat. § 28-328(1)-(4):

(1) No partial-birth abortion shall be performed in this state, unless such procedure is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

(2) The intentional and knowing performance of an unlawful partial-birth abortion in violation of subsection (1) of this section is a Class III felony.

(3) No woman upon whom an unlawful partial-birth abortion is performed shall be prosecuted under this section or for conspiracy to violate this section.

(4) The intentional and knowing performance of an unlawful partial-birth abortion shall result in the automatic suspension and revocation of an attending physician's license to practice medicine in Nebraska by the Director of Regulation and Licensure. . . .

III. U.S. Const. amendment XIV:

The Fourteenth Amendment provides in pertinent part: "Nor shall any State deprive any person of life, liberty, or property without due process of law."

I. STATEMENT OF THE CASE

In the past five years the nation has witnessed an outpouring of public concern over a controversial medical procedure legally denominated as "partial-birth abortion" and now referred to medically as "D&X" abortion.

The United States District Court for the District of Nebraska described the partial-birth abortion/D&X procedure as follows, based on testimony by the Respondent in the present case:

> When the fetus is presented feet first, Carhart, using forceps, pulls the feet of the living fetus from the uterus into the vaginal cavity and then pulls the remainder of the fetus, except the head, into the vaginal cavity to a point where the base of the fetal skull is lodged in the uterine side of the cervical canal. At that point, the size of the head will not permit him to pull it through the cervical canal into the vaginal cavity. To decompress the fetal skull and evacuate the contents in order to pull it through the cervical canal, Carhart uses an instrument to either tear or perforate the skull to allow insertion of a cannula and removal of the cranial contents. Sometimes he will crush the skull rather than pierce it in order to reduce the size of the skull. Brain death occurs sometime during this two-to-three-second reduction procedure, but fetal heart function may continue for several seconds or minutes after the fetus's skull is decompressed.

Carhart v. Stenberg, 11 F. Supp.2d 1099, 1106 (D.Neb. 1998) (Supp.App. 17).

One nurse who personally observed the partial-birth abortion/D&X procedure stated, "I have been a nurse for a long time, and I have seen a lot of death – people maimed in auto accidents, gunshot wounds, you name it. I have seen surgical procedures of every sort. But in all my professional years, I had never witnessed anything like this." *Partial-Birth Abortion Ban Act, 1995: Hearings on H.R. 1833 Before the Senate Judiciary Committee,* 104th Cong. 17-18 (1995) (Statement of Brenda Pratt Shafer, R.N.).

Nurse Shafer described the procedure's effect on a partially-born child as follows:

> [The doctor] brought the ultrasound in and hooked it up so that he could see the baby. On the ultrasound screen, I could see the heart beat. As [the doctor] watched the baby on the ultrasound screen, *the baby's heartbeat was clearly visible on the ultrasound screen.*
>
> [The doctor] went in with the forceps and *grabbed the baby's legs and pulled them down into the birth canal.* Then he delivered the baby's body and the arms – everything but the head. *The doctor kept the head right inside the uterus. . . .*
>
> *The baby's little fingers were clasping and unclasping, and his little feet were kicking. Then the doctor stuck the scissors in the back of his head, and the baby's arms jerked out, like a startle reaction, like a flinch, like a baby does when he thinks he is going to fall.*
>
> *The doctor opened up the scissors, stuck a high-powered suction tube into the opening, and sucked the baby's brains out. Now the baby went completely limp.*
>
> I was really completely unprepared for what I was seeing. I almost threw up as I watched [the doctor] doing these things. Next, [the doctor] delivered the baby's head. He cut the umbilical cord and delivered the placenta. He threw the baby in a pan, along with the placenta and the instruments he had just used. I saw the baby move in the pan. I asked another nurse, and she said it was just reflexes.

Id.

The reaction to the development of this procedure has been truly unprecedented. Nation-wide, large bi-partisan majorities consisting of both pro-choice and pro-life legislators have voted to ban the procedure in thirty

States and both Houses of Congress. The general public clearly does not view the procedure as falling within the liberty right protected by ***Roe v. Wade*** and ***Casey*** due, in large part, to the fact the child is primarily outside the womb when it is killed. The Nebraska Legislature, with only one dissenting vote, passed a ban on the partial-birth abortion/D&X procedure which was signed into law on June 9, 1997. Nebraska's statute was patterned closely after language passed by both Houses of Congress.

Just three days after enactment of Nebraska's statute, and before the statute had been applied in any setting, LeRoy Carhart, a Bellevue, Nebraska physician who performs late-term abortions, filed a pre-implementation Complaint challenging the constitutionality of the statute on its face. On June 17, 1997, the United States District Court for the District of Nebraska entered a Temporary Restraining Order preventing enforcement of the statute. The TRO remained in effect pending disposition of the Plaintiff's Motion For Preliminary Injunction which was heard on July 17 and 18, 1997. On August 14, 1997, the district court entered a preliminary injunction against enforcement of the statute.

Following additional discovery, a trial on the merits was held on March 24, 1998, at which time additional testimony and evidence were received. On July 2, 1998, the district court permanently enjoined enforcement of the statute. Final Judgment was entered on August 10, 1998. A timely appeal was taken to the Eighth Circuit Court of Appeals, and on September 24, 1999, that court affirmed the judgment of the district court.

Notwithstanding the fact that Nebraska's chief legal officer construes the statute as banning only the D&X abortion procedure, the Eighth Circuit read Nebraska's statute as banning both the partial-birth abortion/D&X procedure and the more common D&E procedure. The panel did not reach the issue of whether a State may enact a statute limited only to the D&X procedure, but

concluded that a prohibition encompassing the D&E procedure "imposes an undue burden on a woman's right to choose to have an abortion." ***Carhart v. Stenberg,*** 192 F.3d 1142 (8th Cir. 1999) (Pet.App. 19). A Petition For Writ of Certiorari was filed on November 15, 1999, and on January 14, 2000, the Court entered an order granting the Writ.

II. SUMMARY OF THE ARGUMENT

Over the last five years, thirty States and both Houses of Congress have attempted to regulate an abortion procedure that, in their judgment, is medically unnecessary and looks disturbingly close to infanticide. Supported by Democrats and Republicans, pro-choice and pro-life advocates and medical and non-medical interest groups, partial-birth abortion regulations represent a broad based response to an abortion procedure that was virtually unknown until 1995 and which is widely viewed as outside acceptable medical practice. The American Medical Association has concluded "there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion." ***Hope Clinic v. Ryan,*** 195 F.3d 857, 872 (7th Cir. 1999) (*quoting* AMA Policy H-5.982). To prevent the use of this procedure in Nebraska, the citizens of the State responded with the legislation now before the Court. Patterned after the federal bill passed by both Houses of Congress, the Nebraska law bans "partial-birth abortions," and does so in a constitutionally permissible manner.

Federal courts have a duty to try to save, not destroy, democratically-developed legislation. ***Planned Parenthood Ass'n. Of Kansas City, Mo., Inc. v. Ashcroft,*** 462 U.S. 476, 493 (1983). In concluding that the Nebraska law encompasses not just partial-birth (or D&X) abortions, but the more common D&E procedure as well, the Eighth

Circuit failed to respect this rule in general and in particular the customary benefit of the doubt that the Court gives State and Federal Lawmakers.

First, the law is not an openly-worded Rorschach test. The plain terms of the statute regulate the D&X procedure and no other. The law identifies its single target by name – "partial-birth abortion" – using a phrase that every medical and legislative source to date has understood to refer solely to the D&X procedure. In conspicuous contrast, the D&E procedure is nowhere mentioned and nowhere banned. Making matters more clear, the law proceeds to define the banned procedure as an abortion in which one "partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery." Neb. Rev. Stat. 28-326(9). Then, in an effort to ensure that the law *does not* cover the D&E procedure, the statute indicates that "partially delivers" means "intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person . . . knows will kill the unborn child and does kill the unborn child." ***Id.***

Unlike the D&E procedure, in which the object is to dismember the unborn child, the thrust of the D&X procedure is to kill the child after almost complete delivery – in other words, to deliver the child (e.g., "delivers vaginally a living unborn child") before performing the suction procedure to the child's skull, which the individual "knows will kill" the unborn child and "does" in fact do so. A "living unborn child" simply is not "deliver[ed]" in the D&E dismemberment procedure, accidentally or otherwise, and thus is not covered by the ban. Nor can plaintiffs legitimately seize on the limiting language (a "substantial portion" of the child) to extend the law beyond its D&X mooring. A word is known by the "company it keeps," ***Gutierrez v. Ada,*** ___ U.S. ___, 120 S.Ct. 740, 744 (2000) (*quoting* ***Gustafson v. Alloyd Co.,*** 513 U.S.

561, 575 (1995), and the word "substantial," in context, cannot tenably refer to a dismemberment procedure.

Even if doubt remained regarding the scope of the regulation, the answer was not to invalidate the law in its entirety in this pre-implementation challenge. It was to consider whether other time-honored rules of construction – deference to administrative interpretations, legislative history, the doctrine of constitutional avoidance – clarify any such ambiguity. In point of fact, they do. The Attorney General, Nebraska's top legal official, has disclaimed any intent to construe the statute to apply to the D&E procedure. Just as the United States Department of Justice receives deference regarding its administrative interpretations of a federal statute, so it is appropriate here to defer to the State Attorney General regarding his limiting construction of a state statute. ***Arizonans for Official English,*** 520 U.S. 43 (1997). Likewise, legislative history and statutory purpose, both legitimate sources of legislative meaning under Nebraska law, make clear that the law applies only to the D&X procedure, and never was intended to apply to any other procedure. Lastly, the doctrine of constitutional avoidance demonstrates that this limiting construction of the statute is not only sanctioned by Nebraska law, but by principles of United States constitutional law.

Once it is established that the law does not cover the D&E procedure, it is clear that it does not constitute an undue burden on the right to decide whether to terminate a pregnancy. Both ***Planned Parenthood of Southeastern Pennsylvania v. Casey,*** 505 U.S. 833 (1992), and ***Roe v. Wade,*** 410 U.S. 113 (1973), make clear that a woman's right to choose an abortion is not absolute and that a woman is not "entitled to terminate her pregnancy . . . in whatever way . . . she . . . chooses." ***Roe,*** 410 U.S. at 153.

An abortion regulation that covers one "way" of performing an abortion, while leaving open other safe alternatives, does not constitute an undue burden by any relevant standard of review.

That leaves the Respondent's final argument – that the law imposes an undue burden because a partial-birth abortion may be necessary to preserve the health of the mother in some circumstances. Not so. The medical and legislative testimony made it plain that the partial-birth procedure is *never* medically necessary. Both the AMA and numerous doctors have attested to this fact, making a health exception superfluous and unnecessary. In any event, the Respondent's argument is premature as a matter of law in this pre-implementation challenge. Whether one looks to the "large fraction" test of ***Casey,*** or the "no set of circumstances" test of ***U.S. v. Salerno,*** 481 U.S. 739 (1987), the conclusion is the same: A law cannot be struck in all of its applications when no one alleges that even a small percentage of partial-birth abortions would implicate such a health exception.

III. ARGUMENT

A. INTRODUCTION AND OVERVIEW

The degree to which the various States comprising our federal union may regulate abortion practice has been a divisive and contentious issue for over twenty-five years. In 1992, this Court adopted what was thought to be somewhat of a middle ground between sanctioning abortion on demand and allowing total leeway for States to regulate abortion. The Court held that States could not impose an undue burden on the ability of a woman to decide whether to terminate her pregnancy prior to fetal viability. At the same time, the Court indicated that state regulations would be upheld "which in no real sense deprived the woman of the ultimate decision." ***Planned Parenthood of Southeastern Pennsylvania v. Casey,*** 505

U.S. 833, 875 (1992). The Court pointedly noted that the interests of the States in this area had not, theretofore, been receiving proper "acknowledgment and implementation." ***Casey,*** 505 U.S. at 871. In so doing, the Court affirmed the principle from ***Roe v. Wade*** that a woman's right to choose an abortion is not absolute, nor is she "entitled to terminate her pregnancy . . . in whatever way . . . she . . . chooses." ***Roe v. Wade,*** 410 U.S. 113, 153 (1973).

Despite the Court's statements in ***Casey,*** however, the lower federal courts have failed to show any increased recognition of the States' important interests. Recent legislative action by thirty States to ban a controversial and rare procedure known as partial-birth abortion has highlighted this situation, and has underscored the ultimate question: Did ***Casey*** mean what it says about the States' interests, or can there be no meaningful legislative regulation of abortion in the United States? If the decisions of the lower courts in this case are allowed to stand, there can be little doubt but that abortion is now permissible by virtually any and all means, and the States are powerless to legislate even the most modest restrictions. ***See Hope Clinic v. Ryan,*** 195 F.3d 857, 874 (7th Cir. 1999) (en banc) (noting that acceptance of the position now advocated by the Respondent herein "would amount to a rule that anything goes").

In ***Casey,*** the Court held that the legal framework utilized in much of the prior abortion case law did "not fulfill ***Roe's*** own promise that the State has an interest in protecting fetal life or potential life." ***Casey,*** 505 U.S. at 876. Likewise, the legal framework utilized by the lower courts in this case does not fulfill ***Casey's*** promise that "not all regulations must be deemed unwarranted," ***id.,*** or ***Roe***'s assurance that there is no constitutional right to terminate a pregnancy "in whatever way" one chooses. ***Roe,*** 410 U.S. at 153.

The State of Nebraska does not believe the Court in ***Roe*** or ***Casey*** ever envisioned sanctioning the destruction

of human infants delivered all but inches outside the womb. A large and politically diverse majority of legislators in at least thirty States apparently do not believe this was the Court's intent either. Nonetheless, this case presents the Court with the question of the validity of state bans on this once unthinkable practice.

B. NEBRASKA'S PARTIAL-BIRTH ABORTION STATUTE DOES NOT ENCOMPASS THE MORE COMMON D&E ABORTION PROCEDURE.

The key legal determination made by the Eighth Circuit in this case concerned the scope of Nebraska's partial-birth abortion statute. ***Carhart v. Stenberg,*** 192 F.3d 1142, 1145 (8th Cir. 1999) (Pet.App. 4-5). The court expressly found that the "medical description [of the D&X abortion procedure] is within the definition of partial-birth abortion contained in the Nebraska Statute. . . . " ***Id.*** However, the panel concluded that Nebraska's statute bans not only the D&X procedure, but also the more common D&E (dismemberment) abortion procedure. ***Id.***[2]

This overly broad reading of the statute was erroneous for a number of reasons. First of all, no such application of the statute to the D&E procedure has ever been made or even threatened. Second, the Nebraska Attorney General has expressly disavowed any such construction of the statute or any intent to apply the statute to the D&E, or any other procedure except the D&X. Third, the plain language of the statute does not support such a broad reading. Fourth, the legislative intent behind the statute was clearly to prohibit only the D&X

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[2] The Dilation and Evacuation (D&E) abortion procedure is used in the 13th and subsequent weeks of gestation. It involves extraction of the unborn child from the uterus in pieces through the use of forceps. (Supp. App. 100-101).

procedure. Fifth, important principles of federalism as reflected in fundamental rules of statutory construction dictate a construction of the statute limiting its applicability to the D&X procedure. The following sections will discuss each of these five reasons why Nebraska's statute does not encompass the D&E procedure.

1. No Application of the Statute to the D&E Procedure Has Ever Been Made or Threatened.

Three days after Nebraska's partial-birth abortion statute was signed into law, the Respondent filed suit in federal district court seeking its facial invalidation (J.A. 1); (Eighth Cir. App. 1-19). The statute has never been applied to prohibit D&E abortions; nor has such application ever been threatened.

2. The Chief Law Officer of the State of Nebraska Has Expressly Disavowed Any Intent to Apply the Statute to D&E Abortions.

The Nebraska Attorney General, the chief law officer of the State, has interpreted the statute as encompassing only the D&X procedure, and excluding the D&E procedure. ***Carhart v. Stenberg,*** 192 F.3d at 1150 ("The State argues that LB 23's ban on partial-birth abortion prohibits only the D&X procedure, and not the D&E.") (Pet.App. 16). (***See also*** R.Tr. 28) (Eighth Cir. App. 296) (statement by district court that "it's the State's position that D&E is not prohibited; D&X is prohibited"). Although the Attorney General's construction is not equivalent to that of the Nebraska Supreme Court, it is entitled to deference. This is especially true where a statute is challenged in federal court prior to its application and prior to being interpreted by a state court. ***See Broadrick v. Oklahoma,*** 413

U.S. 601, 618 (1973). ***See also Arizonans for Official English v. Arizona,*** 520 U.S. 43 (1997).

In ***Hope Clinic v. Ryan*** the court noted, "The Attorneys General of Illinois and Wisconsin, the principal defendants, tell us that their statutes are concerned only with the D&X procedure and will be enforced only against its use. That assurance might be enough by itself, in the absence of any contrary indication from the State judiciary, to resolve immediate vagueness concerns." ***Hope Clinic,*** 195 F.3d at 865. In construing the statute as covering only the D&X the court stated, "We believe that state courts are entitled to accept the view of both State's Attorneys General that their laws do not forbid, or even affect, [the D&E] procedure." ***Id.*** at 871. This Court should afford similar deference to the Attorney General's construction of the statute in the present case.

3. The Plain Language of the Statute Does Not Encompass the D&E Procedure.

The Respondent alleges that Nebraska's statute bans the D&E method of abortion because a fetal part could potentially enter the vagina either intentionally or inadvertently during the "disjoining" of the unborn child or when it is brought out in parts during a D&E abortion. According to the Respondent, such an occurrence would fall within the definition of the banned procedure. However, as discussed in detail below, the language of the statute read in its plain, ordinary, and popular sense does not encompass the D&E procedure.

The first sentence of Neb. Rev. Stat. § 28-326(9) provides: **"Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery."** The second sentence adds a scienter requirement and defines "partially delivers" as delivering into the vagina

the entire unborn child or a substantial portion thereof. The second sentence also specifies that the purpose of such partial delivery is the subsequent performance of a procedure that the abortionist knows will kill the child and does kill the child: **"The term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child."** ***Id.*** Therefore, by its express terms, the only conduct that violates the statute is "deliberately and intentionally delivering into the vagina a living unborn child or a substantial portion thereof, for the purpose of performing a procedure that . . . will kill the unborn child and does kill the unborn child."

The elements of the banned method of abortion include the deliberate and intentional 1) partial delivery of a living unborn child vaginally for the purpose of performing a separate death-causing procedure, 2) killing the unborn child by the separate procedure after its partial-delivery and 3) completing the delivery. No method of abortion except the D&X procedure meets these statutory criteria, and thus no other method of abortion is banned by the statute. ***See Richmond Medical Center For Women v. Gilmore,*** 144 F.3d 326, 328-332 (4th Cir. 1998).

The Eighth Circuit, at the urging of the Respondent, focused its analysis on isolated phrases or words in the statute to the exclusion of other language and the statute as a whole. However, when all the statute's language is given effect and read in context, the Court need not even resort to the doctrine of constitutional avoidance to uphold the law. Under Nebraska law, "[i]n construing a statute, a court must determine and *give effect to the purpose and intent of the Legislature as ascertained* from the

entire language of the statute considered in its *plain, ordinary, and popular sense.*" ***Stenberg v. Moore,*** 602 N.W.2d 465, 472 (Neb. 1999) (emphasis added). As explained in more detail below, the language of the statute "read in its plain, ordinary and popular sense" reveals that D&E abortions are not covered by its terms. Nebraska's statute does not ban any method of abortion except the D&X procedure.

a. The expressly stated subject of the statute, "partial-birth abortion," cannot be read as referring to the D&E procedure.

The first sentence of the statute begins by stating its subject: "*partial-birth* abortion." Neb. Rev. Stat. § 28-326(9) ("Partial-birth abortion means an abortion procedure. . . . "). Somehow the statute's first word, "partial-birth", was ignored by the courts below, which construed the statute as covering dismemberment (D&E) abortions. A "birth" (partial or otherwise) does not entail just moving human extremities, such as an arm or a leg, beyond the cervix. As the statute's second sentence clearly states, the "partial-birth" procedure involves an unborn child being *delivered* ("delivers vaginally a living unborn child"). Any reading of the term "partial-birth" in its plain, ordinary and popular sense would necessarily exclude all recognized abortion procedures except the D&X procedure. ***See Hope Clinic v. Ryan,*** 195 F.3d at 865 ("Both medical and popular literature equate 'partial-birth abortion' (the statutory term) with the D&X procedure.").

The phrase "partial-birth abortion" has never been used in any context (legal, medical or popular usage) to refer to the D&E procedure. No reasonable person would read "partial-birth" as referring to a dismemberment abortion. Ironically, the Eighth Circuit has specifically acknowledged that *"The term 'partial-birth abortion' . . . is* **commonly understood** to refer to a **particular procedure**

known as intact dilation and extraction (D&X)." ***Little Rock Family Planning Services v. Jegley,*** 192 F.3d 794, 795 (8th Cir. 1999) (emphasis added). Whereas Nebraska law requires that a court give effect to the purpose and intent of the Legislature as ascertained from the entire language of the statute considered in its plain, ordinary, and popular sense, ***Stenberg,*** 602 N.W.2d at 472, all terms and provisions of the statute in question must be read in light of its expressly stated purpose – the banning of *"partial-birth"* abortion.

b. The phrase "partially delivers vaginally a living unborn child" does not, by its terms, refer to a D&E abortion.

The statute provides that "Partial-birth abortion means an abortion procedure in which the person performing the abortion partially *delivers* vaginally a *living unborn child* before killing the unborn child and *completing the delivery*." Neb. Rev. Stat. § 28-326(9) (emphasis added). The words "delivery" and "delivers," in their plain, ordinary, and popular sense, refer to extraction of a baby, not piece by piece dismemberment. Likewise, "living unborn child" reasonably refers to a baby, not pieces thereof. Thus, the statute's terms do not reasonably refer to dismemberment (D&E) abortions, and the Court must give effect to the purpose and intent of the Nebraska Legislature as evidenced by these terms in their ordinary and popular sense.

c. The statute cannot be read as including D&E procedures since it distinguishes between the overall "abortion procedure" itself and the separate "procedure" used to kill the unborn child.

Nebraska's statute initially refers to partial-birth abortion as "an abortion procedure." Neb. Rev. Stat.

§ 28-326(9) (first sentence). It then further defines this overall procedure by reference to a series of elements, one of which is a separate and distinct "procedure" used to kill the child ***Id.*** (second sentence). Specifically, the statute says the intentional delivery of the living unborn child into the vagina is "for the *purpose* of performing *a procedure* that the person performing *such procedure knows will kill* the unborn child. . . . " ***Id.*** (emphasis added). The statute further indicates the separate and distinct nature of the death-causing procedure in that it specifically refers to "completing delivery" *after* performance of the death-causing procedure. Neb. Rev. Stat. § 28- 326(9) (first sentence). Thus, a distinguishing feature of the statute is its focus on the place where the killing act occurs.

Against this statutory backdrop, the Respondent's assertion that the statute encompasses the accidental or intentional entry of a body part into the vagina during a D&E (dismemberment) abortion is an untenable reading of the statute's terms. In a D&E procedure, the intent is never to deliver the unborn child into the vagina so that it may then be killed. Furthermore, in a D&E abortion there is no distinction between the overall "abortion procedure" and the "procedure" used to kill the child. As shown above, Nebraska's partial-birth abortion statute clearly does make such a distinction. The delivery of the child into the vagina "for the purpose of performing" a separate and certain death-causing procedure distinguishes the partial-birth abortion procedure from all other abortion procedures. The testimony of the Respondent himself confirms this fact. Dr. Carhart testified that in a D&E abortion the unborn child will continue living after it has been partially dismembered, due in part to the continuing blood supply from the placenta to the child. (J.A. 64) ("[W]e can still see fetal heart activity with extensive parts of the fetus removed."). Consequently, he testified that he *does not know when death will occur* in a

D&E. (J.A. 62-64). In contrast, the statute says the separate death-causing procedure in a partial-birth abortion is one which "the person performing such procedure *knows will kill* the unborn child." After initially evading the question, Dr. Carhart acknowledged that brain function ceases quickly when the brain suctioning is done in a D&X. (J.A. 60). Thus, the uncertainty as to when death will occur in a D&E procedure clearly distinguishes the D&E procedure from the partial-birth abortion/D&X procedure under the terms of the statute.[3] The Respondent may argue that the "removal of the fetal extremities" (mechanical removal of arms and legs) in a D&E abortion is "a procedure" that causes death and, therefore, is covered by the statute. However, this interpretation would require the Court to equate multiple, random acts of dismemberment (which may or may not, by themselves, kill the child) with "a procedure that the person performing such procedure *knows will kill* the unborn child *and does kill* the unborn child." Neb. Rev. Stat. § 326(9) (emphasis added). Such an interpretation would be clearly inconsistent with the plain language of the statute.[4]

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[3] In ***Little Rock Family Planning Services v. Jegley,*** 192 F.3d 794 (8th Cir. 1999) the court acknowledged that in a D&E procedure where an arm or leg are removed from the child's body "[t]he rest of the fetus remains in the uterus while dismemberment occurs, and is often *still living*." ***Id.*** at 797 (emphasis added). The court's acknowledgment that the child is often still living after a body part or parts have been severed in a D&E is highly significant since the express language of the Nebraska statute clearly contemplates partial delivery followed by the doctor "performing a procedure that the person performing such procedure *knows will kill* the unborn child *and does kill* the unborn child." This language distinguishes a D&X procedure from a D&E procedure and cannot be ignored.

[4] The Eighth Circuit, in its analysis of this language, stated, "A physician who brings an arm or a leg into the vagina ***as part***

d. The phrase "substantial portion," when read in context, refers to a partially delivered child and not to a dismemberment procedure.

The statutory language that is the focus of the Respondent's challenge is the phrase "substantial portion." The analysis of this challenged language is set forth last since under Nebraska law it must be read together with, and in the context of, the preceding language which rules out the D&E procedure from the statute's coverage.[5]

The Respondent deliberately isolates the phrase from its context, and then alleges that it encompasses the D&E procedure.[6] When removed from its context, even the State's witnesses candidly acknowledged the inherent "germs of uncertainty" that this Court has said are inherent in any word. ***Broadrick v. Oklahoma,*** 413 U.S. at 608. However, in the context of the statutory terms discussed above, the phrase "substantial portion" logically refers only to a substantial portion of the entire body of the

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of the D&E procedure therefore violates the statute." ***Carhart,*** 192 F.3d at 1150 (emphasis added). Thus, the circuit court expressly equated the separate death-causing procedure referenced in the statute with "part of the D&E procedure." This construction ignores the plain language of the statute which references "completing the delivery" as a step of the banned procedure occurring subsequent to "killing the unborn child" by "a procedure that the person . . . knows will kill . . . and does kill the unborn child." Neb. Rev. Stat. § 28-326(9).

[5] In contrast, the Eighth Circuit began its analysis by examining this phrase, and it did so in isolation from its context. ***Carhart,*** 192 F.3d at 1150.

[6] (***See*** J.A. 37) ("I want to focus your attention on the term substantial portion."). The court's analysis in ***Richmond Medical Center For Women v. Gilmore,*** 144 F.3d 326 (4th Cir. 1998), exposes the Respondent's litigation strategy of isolating the phrase "substantial portion" from its context.

partially delivered living child – again, due to the use of such modifying phrases as "intentionally delivering" a "living unborn child."

Due to the scienter provision contained in the same sentence of the statute, as well as the other terms in the statute which distinguish the banned procedure from the D&E (or any other abortion procedure), the meaning of "substantial portion" is *never an issue* for a physician not intentionally performing a D&X procedure. In other words, other provisions of the statute eliminate the D&E procedure from consideration before this phrase ever becomes an issue. This is not to say the phrase is meaningless. To constitute an element of the banned procedure, according to the terms of the statute, the delivery of the unborn child from the womb into the vaginal canal can be either complete ("delivering into the vagina a living unborn child") or "a substantial portion thereof." Thus, the phrase is needed to prevent avoidance of the statute on the basis the entire child must be delivered into the vagina.

When read in its context the phrase describes the D&X procedure, where all but the head of the child is delivered outside the uterus. As Dr. Boehm testified, in a partial-birth abortion "[a] significant portion of the fetus is outside of the vagina. Otherwise, it's difficult . . . to put a . . . trocar through the base of the skull underneath the cervical realm." (J.A. 664); (***See also*** J.A. 663). In other words, if the child's body were not delivered through the cervical os at least up to the head, it would be difficult, if not impossible, to pierce the child's skull. Consequently, the Nebraska Attorney General interprets the phrase "substantial portion," when read in the context of the overall statute, as meaning the child up to the head.[7]

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[7] The legislative history of this language shows that this was the intended meaning. (Eighth Cir. App. 1640) ("The abortionist then delivers the baby's entire body except the head.") (opening statement by sponsoring senator). The "substantial portion" language was specifically added to the statute to further distinguish the D&X procedure from dismemberment abortions in order to assure support for the statute from the AMA. (Eighth Cir. App. 1779). This overriding fact dispels any confusion resulting from attempts by one opponent during floor debate to isolate the term from the rest of the statute and thereby lead proponents down rabbit trails, debating how much of an unborn child is "substantial." There is no evidence of any abortion technique in which a death-causing procedure is performed, under the specifications of the statute, where the child is delivered less than up to the head.

The Respondent's alleged confusion concerning the meaning of "substantial portion" is self-induced.[8] As one federal court noted, the "Plaintiffs' alleged confusion concerning the meaning of [Wisconsin's partial-birth abortion statute] is a demon of their own creation." ***Planned Parenthood of Wisconsin v. Doyle***, 9 F. Supp.2d 1033, 1041 (W.D. Wis. 1998) (subsequent history omitted). ***See also Gilmore***, 144 F.3d 326. In sum, the Respondent's focus on, and objection to, the "substantial portion" language in the statute is a litigation tactic designed to play upon the inherent "vagueness" one can find in any common term when it is deliberately isolated from its context. ***Broadrick***, 413 U.S. at 608. As discussed above, other provisions in Nebraska's statute rule out D&E abortions, thus making the meaning of the phrase "substantial portion" irrelevant to any procedure other than a D&X.

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[8] The Respondent testified that, in his view, extraction of the umbilical cord could fall within the conduct prohibited by the statute. (J.A. 37). This absurd interpretation demonstrates the strained nature of the Respondent's construction.

4. The Expressly Stated Purpose for Enactment of the Statute by the Nebraska Legislature Confirms its Applicability Only to the D&X Procedure.

The State believes the language of the statute, read in its plain, ordinary, and popular sense, excludes the D&E procedure. However, in the event the Court finds any term in the statute to be ambiguous, even when read in the context of the entire statute, the next avenue for ascertaining the law's purpose and intent is to examine its legislative history.[9] ***Pump & Pantry, Inc. v. City of Grand Island,*** 444 N.W.2d 312, 316 (Neb. 1989). The legislative intent of Nebraska's statute is clear. The first words spoken by the sponsoring senator during legislative consideration of the bill were as follows:

> My personal priority bill, LB 23, would prohibit the use of ***partial-birth abortion*** procedure, ***also known as dilation and extraction,*** in the state of Nebraska.

Floor debate on LB 23, April 11, 1997, p. 3955 (emphasis added) (Eighth Cir. App. 1639). Thus, it was clear from the very beginning that the statute's intent was to ban the D&X procedure.

In addition, the legislative history of the amendment which added the "substantial portion" language (the phrase which is the focus of the Respondent's challenge) shows that this provision was actually added to the statute *for the purpose of clarifying that the D&E procedure was not covered by the bill.* During floor debate on May 20, 1997, the bill's sponsor reported that "The changed language is in the bill now: [it] 'makes it *clear beyond any*

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[9] The full legislative history of the Act is found in the Eighth Circuit Appendix, Vol. VII, pp. 1627-2026. *See* S.Ct. Rule 26(2). The State chose not to burden the already large Joint Appendix with its inclusion. Only portions selected by the Respondent appear in the Joint Appendix.

question that the accepted abortion procedure known as dilation and evacuation, also referred to as **D&E, is not covered** by the bill. . . . " (Eighth Cir. App. 1779) (Statement by Senator Maurstad, quoting a statement from the American Medical Association (AMA) in support of a ban on partial-birth abortion using the same language) (emphasis added). Similarly, pro-choice Senator Pam Brown stated that "in the opinion of the AMA the bill has no impact on a woman's right to choose an abortion, consistent with ***Roe v. Wade*** . . . other abortion procedures . . . remain fully available." (Eighth Cir. App. 1805). The reason the bill's sponsor, as well as pro-choice supporters, were quoting the AMA's statement was that the congressional bill upon which Nebraska's statute was patterned had been amended to assure the AMA that the D&E procedure was not covered by the statute.

The Respondent asks the Court to believe that the legislatures of thirty States (including many or most of the pro-choice legislators in those States) have conspired to enact a ban on virtually all abortion procedures. Alternatively, he would ask the Court to believe these thirty legislatures were all ignorant of what they were legislating. The Petitioners believe these legislatures, and particularly the Nebraska Legislature, knew exactly what they were doing – banning the D&X procedure.

5. The Doctrine of Constitutional Avoidance, As Well As Principles of Federalism and Administrative Deference Require the Statute to Be Read as Not Covering D&E Abortions.

Even if the Court should deem it necessary to resort to rules of statutory interpretation beyond the plain terms of the statute and the legislative history, the result is the same. As discussed below, the doctrines of constitutional avoidance and administrative deference require the statute to be read as not encompassing the D&E procedure.

a. Nebraska's statute must be interpreted according to fundamental rules of construction which afford proper deference to state legislative enactments.

Nebraska's statute must be interpreted according to fundamental rules of construction. These rules reflect basic tenents of federalism, and they therefore require proper deference to state legislative enactments.

i. A federal court is obliged to presume that the intent of the statute is within constitutional bounds and to favor an interpretation of the statute that renders it constitutional.

This Court has long held that a federal court is obliged to presume a legislative intent to act within constitutional bounds, and to favor an interpretation of a statute that renders it constitutional. ***De Bartolo Corp. v. Florida Gulf Coast Building, and Construction Trades Council,*** 485 U.S. 568, 575 (1988) (*quoting* ***Hooper v. California,*** 155 U.S. 648, 657 (1895)).

In ***Webster v. Reproductive Health Services,*** 492 U.S. 490 (1989), the Court considered the constitutionality of a Missouri statute that required viability testing "[b]efore a physician performs an abortion on a woman he has reason to believe is carrying an unborn child of twenty or more weeks gestational age. . . . " ***Id.*** at 513. Several Justices criticized the Eighth Circuit panel (which had declared the statute unconstitutional) for its interpretation of the statute which "runs 'afoul of the well-established principle that statutes will be interpreted to avoid constitutional difficulties.' " ***Id.*** at 514 (quoting ***Frisby v. Schultz,*** 487 U.S. 474, 483 (1988)). The Justices stated the panel's reading of the statute "violates well-accepted canons of statutory interpretation. . . . " ***Id.*** at 515 (noting that the law favors saving constructions of challenged

statutes). In the present case, the Eighth Circuit again failed to follow this basic rule of statutory construction.[10]

ii. The Court must ascertain whether a construction of the statute is fairly possible by which constitutional doubts may be avoided and must accord the statute that meaning.

Under the doctrine of constitutional avoidance, the test is not whether a statute could possibly be construed in an unconstitutional manner, but whether the law is susceptible of a reasonable interpretation which supports its constitutionality. ***United States v. National Dairy Products Corp.,*** 372 U.S. 29, 32 (1963). The Court has held that "as between two possible interpretations of a statute, by one of which it would be unconstitutional and by the

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[10] The Eighth Circuit's adoption of an unconstitutional construction of Nebraska's partial-birth abortion statute was particularly inappropriate given the availability under Nebraska law of a mechanism for obtaining a definitive interpretation of the statute from the Nebraska Supreme Court. Neb. Rev. Stat. § 24-219. The State requested the district court to abstain in light of the fact the statute had not been construed by the Nebraska Supreme Court. (Eighth Cir. App. 38). However, the court did not. Given the availability of a reasonable constitutional construction of the statute, the State does not believe that certification of any questions is necessary. Nevertheless, if following briefing and oral argument, this Court has any unresolved questions regarding the proper interpretation of the scope or application of the statute, the answers to which could affect the constitutionality of the statute, then the Court could certify those questions to the Nebraska Supreme Court for prompt resolution. Since the certification statute was enacted, the Nebraska Supreme Court has answered almost three dozen questions certified by federal courts, over half of which arose in the context of a single abortion case. ***See Orr v. Knowles,*** 337 N.W.2d 699 (Neb. 1983).

other valid, our plain duty is to adopt that which will save the Act." *Id.* Similarly, this Court has held that, "It is a 'cardinal principal' that [federal courts] are to ascertain whether a construction of the statute involved is 'fairly possible' by which such constitutional doubts may be avoided." *Johnson v. Robison*, 415 U.S. 361, 366-367 (1974).

When reviewing a state legislative enactment pertaining to abortion, a federal court is not to merely accept the interpretation proffered by the party seeking to invalidate the statute. *Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft*, 462 U.S. 476, 496 (1983). The Court has held that "every reasonable construction must be resorted to, in order to save a statute from unconstitutionality." *Rust v. Sullivan*, 500 U.S. 173, 190 (1991).

These rules of construction/federalism are particularly important when considering partial-birth abortion statutes. *See Hope Clinic*, 195 F.3d 857; *Gilmore*, 144 F.3d at 332; *Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187, 212 (6th Cir. 1997) (Boggs, dissenting) ("The Supreme Court has reminded us time and again that, rather than reaching out to strike down statutes that are arguably unconstitutional, the federal courts are to interpret statutes so as to avoid difficult constitutional questions where possible.").

iii. Nebraska's statute may be construed in a constitutional manner.

When the above rules of construction are applied, Nebraska's statute can easily be construed as banning only the D&X procedure. As described in detail above, a construction of Nebraska's partial-birth abortion statute is fairly possible by which its application is limited to the D&X. An analysis of this same issue with regard to a

virtually identical statute[11] was set forth in *Richmond Medical Center for Women v. Gilmore*, 144 F.3d 326 (4th Cir. 1998). *Accord Hope Clinic*, 195 F.3d 857. These opinions provide sufficient grounds to reverse the decision of the Eighth Circuit, as they clearly demonstrate that a construction of the statute is fairly possible by which constitutional doubts may be avoided. *Webster*, 492 U.S. at 514; *Ashcroft*, 462 U.S. at 493.

Further aiding a constitutional construction of Nebraska's statute is its clear scienter provision. *See Hope Clinic*, 195 F.3d at 867. Unlike some partial-birth abortion statutes, Nebraska's statute has an express intent or scienter requirement. *Compare Evans v. Kelley*, 977 F. Supp. 1283, 1308-1309, 1311 (E.D. Mich. 1997). In *Evans*, the court found that the Michigan statutes' "lack of an explicit intent requirement . . . makes the statute particularly susceptible to ambiguous interpretation and unpredictable enforcement." *Id.* at 1308.[12] Conversely, in *Doyle*, the court noted, in its analysis of Wisconsin's partial-birth abortion statute, that "A scienter requirement significantly diminishes a statute's susceptibility to discriminatory enforcement." *Doyle*, 9 F. Supp.2d at

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[11] The district court in the present case specifically acknowledged that "Virginia's partial birth abortion law is nearly identical to Nebraska's." *Carhart*, 11 F. Supp.2d at 1129. (Supp.App. 80).

[12] It is noteworthy that despite its invalidation of the Michigan statute, the *Evans* court stated that "the Legislature can, consistent with *Casey* and other Supreme Court precedent, tailor an abortion regulation that would avoid the pitfalls of vagueness and overbreadth and pass constitutional muster." *Evans*, 977 F. Supp. at 1319 n.38. ***The court then discussed, at considerable length, an example of more carefully and precisely drawn legislation: the precise language now contained in Nebraska's statute. Id.*** at 1311 n.29, 1319-1320 n.38.

1040.[13] The court specifically held that "The scienter requirement in Wisconsin's law protects physicians against inadvertent violations of the law." *Id.* at 1043. ***See also Gilmore***, 144 F.3d at 328-332 (detailed analysis of the significance of the scienter requirements of a partial-birth abortion statute nearly identical to Nebraska's statute).

b. A variation of *Chevron* deference applies to require the statute be read as not covering D&E abortions.

Federal courts defer to an interpretation of a federal law offered by the federal official responsible for administering it, particularly with respect to those interpretations that are consistent with the rules of statutory construction. ***Chevron v. Natural Resources Defense Council***, 467 U.S. 837, 844 (1984). The federal government also receives deference from federal courts regarding interpretations of statutes offered by the Department of Justice and other federal agencies. **See *Olmstead v. Zimring***, 527 U.S. 581, 119 S.Ct. 2176, 2186 (1999). The same rule should apply to the States, and in view of separation of powers and federalism concerns, should apply even more vigorously to the States. ***See Arizonans for Official English***, 520 U.S. 43 (1997). As discussed ***infra*** at 12-13, Nebraska's Attorney General has construed the challenged statute as encompassing only the D&X procedure. Consequently, Nebraska's statute must be read as not covering D&E abortions.

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[13] This decision was reversed by ***Planned Parenthood of Wisconsin v. Doyle***, 162 F.3d 463 (7th Cir. 1998), but its analysis was eventually vindicated by ***Hope Clinic v. Ryan***, 195 F.3d 857 (7th Cir. 1999) (en banc).

C. NEBRASKA'S BAN ON PARTIAL-BIRTH ABORTION DOES NOT PLACE A SUBSTANTIAL OBSTACLE IN THE PATH OF A WOMAN SEEKING TO TERMINATE HER PREGNANCY AND THEREFORE DOES NOT CREATE AN UNDUE BURDEN.

Properly construed as encompassing only the D&X procedure, Nebraska's partial-birth abortion statute does not place a substantial obstacle in the path of a woman seeking to terminate her pregnancy, and therefore does not create an undue burden. As discussed in detail below, the Court's decisions in ***Roe v. Wade*** and ***Casey*** leave ample room for States to ban one type of abortion procedure where other safe alternatives remain available. Furthermore, neither ***Roe*** nor ***Casey*** contemplated the killing of infants while delivered mostly outside of the womb.

The central holding of ***Roe v. Wade***, as affirmed in ***Casey***, was predicated on certain "factual underpinnings." ***Casey***, 505 U.S. at 860. Among these underpinnings was the public's understanding of what constituted an "abortion." As the controlling opinion in ***Casey*** noted, "abortion . . . is more than a philosophic exercise. Abortion is a unique act. It is an act fraught with consequences for . . . society which must confront the knowledge that these procedures exist. . . . " ***Casey***, 505 U.S. at 852.

The Court noted that "In constitutional adjudication as elsewhere in life, changed circumstances may impose new obligations. . . . " ***Casey***, 505 U.S. at 864. However, the Court concluded that "neither the factual underpinnings of ***Roe's*** central holding nor our understanding of it has changed. . . . " ***Id.*** The present case, however, does involve a change in a factual underpinning, and is before the Court precisely because the public's understanding of what constitutes a legal abortion simply does not include

the partial-birth abortion/D&X procedure. This is evidenced, in part, by the overwhelming legislative sentiment to ban the procedure in at least thirty States and Congress. In short, the public does not believe the partial-birth abortion/D&X procedure falls within the realm of conduct protected by ***Roe*** and ***Casey,*** and a determination to the contrary would, in the Petitioners' view, not be accepted as "a common mandate rooted in the Constitution.", ***id.*** at 867, due to the scope of protected activity having "changed so fundamentally." ***Id.*** at 868.

1. The Absence of a Health Exception in Nebraska's Statute Does Not Create an Undue Burden Since No Health Exception Is Needed Where Safe Alternative Procedures Are Available.

Banning the D&X abortion procedure does not keep any woman from obtaining a safe abortion. Nebraska's statute contains an exception allowing use of the partial-birth abortion procedure if ever necessary to save the life of the mother. Neb. Rev. Stat. § 28-328(1). However, the Nebraska Legislature omitted a general "health" exception as being unnecessary. As discussed in detail in the sections below, partial-birth abortion is not medically necessary, and safe alternative methods of abortion are available. Neither the Respondent nor any other plaintiff in any state has identified any articulable, concrete category of situations in which the D&X procedure is even the best option. ***See Hope Clinic,*** 195 F.3d at 872 (noting district court finding that the D&X "is never necessary" from the perspective of the woman's health, and that ACOG could "not identify any concrete circumstances" under which the D&X is the best option). Since the statute does not affect the "right to choose" an abortion (since other safe procedures remain available) the right itself

still remains protected by a health exception. ***See Hope Clinic,*** 195 F.3d at 871 (health exception not necessary when the procedure lacks demonstrable health benefits and where state law offers safe alternative abortion procedures). Thus, the absence of a health exception in the statute does not create a substantial obstacle to the right to choose to terminate a pregnancy.[14]

Just as important, no evidence supports the notion that a health exception would be necessary in all circumstances, ***U.S. v. Salerno,*** 481 U.S. 739 (1987), or even in a large fraction of circumstances (***Casey***).[15] ***See Hope Clinic,*** 195 F.3d at 874 ("even for the class of women who seek late-second-trimester abortions, there is always one or more other safe methods of abortion in addition to D&X"). That alone dooms the Respondent's challenge.

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[14] The alternative is not consistent with ***Casey***. As the Seventh Circuit stated, "A requirement of a case-by-case 'health exception' to every statute concerning abortion would amount to a rule that no state may regulate any abortion procedure." ***Hope Clinic,*** 195 F.3d at 973.

[15] The relevant class under the large fraction rule cannot consist of one hypothetical woman as the district court below seemed to conclude. ***See Hope Clinic,*** 195 F.3d at 874 (rejecting the relevant class formulation utilized by the district court herein). Such an application of the large fraction rule would turn ***Salerno*** on its head. Furthermore, such a test would effectively eliminate the distinction between a facial and an as-applied challenge. The two would be merged into one nearly impossible test under which any statute would be one doctor's opinion away from invalidation.

2. The Effect Of Nebraska's Statute Is To Ban One Unnecessary and Rare Procedure, And It Does Not Place A Substantial Obstacle In The Path Of A Woman Seeking To Terminate Her Pregnancy.

a. The partial-birth abortion/D&X procedure is rare and unnecessary.

Partial-birth/D&X abortion is a relatively little-used procedure that is performed only by a handful of doctors. Dr. Henshaw, the Respondent's own expert, testified that "to my knowledge, there are only a few doctors nationally who do large numbers of D&X abortions." (J.A. 27-28). Out of approximately sixty physician plaintiffs in partial-birth abortion cases nationwide only two doctors other than the Respondent acknowledged using the D&X procedure, one of which testified he did only 2-3 a year. *See* Brief of Amicus Curiae Family First. Even for the few doctors who use the procedure, it is of limited application. The Respondent acknowledges the procedure is not practical prior to 16 weeks, and is not used by him after 19 weeks (since he kills unborn children in utero by injection prior to extraction after that time). In the time between, the procedure is unpredictable, and intact extraction fails, according to the Respondent, 90-95% of the time. (J.A. 61).[16]

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[16] The D&X procedure is typically used late in the second trimester, between the twentieth and twenty-fourth weeks of pregnancy, inclusive. ***Voinovich***, 130 F.3d at 198. In ***Planned Parenthood of Southern Arizona, Inc. v. Woods***, 982 F. Supp. 1369 (D.Ariz. 1997), the only reported testimony on the timing of the procedure was that it was performed from 22 to 24 weeks. ***Id.*** at 1375. This time frame is consistent with testimony before Congress. ***See*** Partial-Birth Abortion Ban Act of 1997, H.Rep. 105-24, March 14, 1997 at 4 ("The partial-birth abortion procedure is performed from around 20 weeks to full term"). In fact, "Dr. Haskell claims to have developed the method for use

The partial-birth abortion/D&X procedure is an unnecessary and little used procedure which the elected representatives of the people of the State of Nebraska have determined to be outside the scope of accepted medical practice.

b. The State may ban a particular abortion procedure where there are safe alternatives available.

Contrary to the position advocated by the Respondent, there are constitutionally permissible limits on what procedures may be used to terminate a pregnancy. In ***Roe v. Wade***, the Court stated that "appellant and some *amici* argue that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, *in whatever way*, and for whatever reason she alone chooses. *With this we do not agree.*" ***Roe***, 410 U.S. at 153 (emphasis added).

The most basic limitation stems from the definition of abortion itself. An abortion is the intentional premature termination of a pregnancy. Neb. Rev. Stat. § 28-326 (1995).[17] The intentional killing of an infant (whether

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at twenty weeks and beyond. . . . " Partial-Birth Abortion Ban Act of 1995, H.R. 1833, Hearing Before the Committee on the Judiciary of the Senate, November 17, 1995, p. 347.

Dr. Carhart admits that he can and does attempt to induce fetal death by injection in utero 48 to 72 hours before beginning abortion procedures after the 20th week of gestation. ***Carhart v. Stenberg***, 972 F. Supp. at 514. (Supp.App. 18). Furthermore, he admits there is a medical benefit to the mother in doing so. (J.A. 65). The Respondent testified that, contrary to other practitioners, he "attempts" to perform the D&X procedure at 16 weeks (J.A. 61), even though he admits it almost always fails until much later (J.A. 61).

[17] Pregnancy occurs "within the uterus." ***McNill v. New York City Dept. of Corrections***, 950 F. Supp. 564, 569 (S.D.NY.

viable or not) after live delivery is not an abortion, but rather homicide.[18] Consequently, there are limits on what medical procedures may be used to perform an "abortion."[19]

With this foundation, the key question in this case is "under what circumstances may a State ban a particular abortion procedure without creating an undue burden?" As discussed in detail above, ***Casey*** protects the right to choose whether to terminate a pregnancy. It does not guarantee a right to an abortion by any or all means. Only where a substantial obstacle is imposed on the right to choose *whether* to abort is an undue burden created. Thus, where a State attempts to ban a particular abortion procedure the question presented under the undue burden analysis of ***Casey*** is whether there are safe alternative procedures available to women seeking abortions.[20]

1996). Pregnancy differs from parturition or childbirth. ***See, e.g., Kirkhuff v. Nimmo,*** 683 F.2d 544, 549 (D.C. Cir. 1982). During the partial-birth abortion procedure the child is three-fourths outside the uterus.

As discussed in this section Nebraska's statute does not create an undue burden under the ***Casey*** test. Alternatively, it may also be upheld under a balancing test applicable to partially-born children since ***Roe v. Wade*** and ***Casey*** dealt only with the "unborn." ***See*** Brief of Amicus Curiae National Right to Life Committee.

[18] ***See, e.g.,*** Neb. Rev. Stat. § 28-302(2) (defining "person, when referring to the victim of a homicide" as "a human being who had been born and was alive at the time of the homicidal act."); ***Showery v. Texas,*** 690 S.W.2d 689 (Tex.App. 1985).

[19] For example, if an abortion procedure results in a live birth, the abortionist may not then kill the child as part of his "procedure." ***See, e.g.,*** Neb. Rev. Stat. § 28-331 (requiring preservation of the life of a child born alive as the result of an abortion).

[20] This framing of the issue is consistent with ***Mazurek v. Armstrong,*** 520 U.S. 968 (1997), in which the Court upheld the

c. Safe alternatives to partial-birth abortion/D&X are available.

According to the American Medical Association, D&X abortion "is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development." ***Voinovich,*** 130 F.3d at 214 (Boggs, dissenting) (quoting AMA position statement). ***See Hope Clinic,*** 195 F.3d at 872 ("there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion.") (quoting AMA Policy H-5.982). Even the inventor of the procedure says it is never medically necessary. ***Planned Parenthood of Wisconsin v. Doyle,*** 44 F. Supp.2d 975, 980 (W.D. Wis. 1999) ("[Dr.] Haskell, who invented the D&X procedure, admitted that the D&X procedure is never medically necessary to . . . preserve the health of a woman."). Likewise, the American College of Obstetricians and Gynecologists, a staunch opponent of all legal restrictions on abortion, including bans on partial-birth abortion, has reported that *"A select panel convened by ACOG could identify no circumstances under which this [D&X] procedure . . . would be the only option to save the life or preserve the health of the woman."* (emphasis added) (J.A. 1484). In other words, safe alternatives to partial-birth abortion remain available under Nebraska's statute as discussed below.

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ability of States to ban abortions by non-physicians even though it is possible some nurses or other professionals could perform abortions as skillfully as some physicians. ***See Hope Clinic,*** 195 F.3d at 873.

i. Both the D&E abortion procedure and the induction procedure are safe alternatives available under Nebraska law.

Nationwide, the testimony in partial-birth abortion cases establishes that both the D&E abortion procedure and the induction procedure[21] are safe alternative procedures. ***See, e.g., Evans,*** 977 F. Supp. at 1294 (testimony by five doctors that "the D&E procedure is a safe procedure"); ***Planned Parenthood of Southern Arizona Inc. v. Woods,*** 982 F. Supp. 1369, 1376 (D.Ariz. 1997) (finding of fact by the district court that D&E is a safe, medically acceptable abortion method in the second trimester); ***Doyle,*** 9 F. Supp. at 1045 (D&E is a "safe procedure"). ***See also Woods,*** 982 F. Supp. at 1376 (finding of fact that induction is a safe, medically acceptable abortion method in the second trimester); ***Planned Parenthood of Greater Iowa v. Miller,*** 1 F. Supp.2d 958 (S.D. Iowa 1998) (induction is a safe, routinely performed procedure after 15 weeks). These findings and testimony confirm the credibility of the State's witnesses in the present case regarding the safety of both procedures. (J.A. 636).

In light of the fact that the D&E and induction procedures are safe procedures for the mother, a ban on only the partial-birth abortion/D&X procedure would still leave women with safe alternatives. ***See Doyle,*** 9

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[21] The induction procedure is used after 15 weeks of gestation. Modern inductions involve induced labor and delivery through the use of prostaglandins. (***See*** Supp.App. 24-25). Although once considered less safe than the D&E, the evidence now shows that modern inductions are equally safe, if not safer, during the gestational period at issue in this case. (J.A. 696); (R.Tr. 306) (Eighth Cir. App. 575); ***Hope Clinic,*** 995 F. Supp. at 852; ***Planned Parenthood of Central New Jersey v. Verniero,*** 22 F. Supp.2d 331 (D.N.J. 1998); ***Evans v. Kelley,*** 977 F. Supp. at 1295 (inductions are safer than D&E after 18 weeks).

F. Supp.2d at 1044 ("Both the American Medical Association and the American College of Gynecologists recognize that a ban on intact D&E's leaves women with other appropriate abortion options.").[22]

ii. The rare complications and extreme cases put forth by the Respondent do not require partial-birth abortion.

Rare or unique fact patterns or hypothetical complications are not sufficient to invalidate the statute. ***Webster,*** 492 U.S. at 524 (O'Connor, J., concurring). Furthermore, even the rare complications and extreme cases postulated by the Respondent do not require partial-birth abortion.

Dr. Frank Boehm, objectively one of the top OB-GYNs in the U.S.[23], testified that Nebraska's ban on partial-birth abortion would not increase a woman's risk of disseminated intravascular coagulopathy (DIC) (J.A. 642-643). Likewise, he testified that banning partial-birth abortion would not enhance or increase the risk to women of amniotic fluid embolus. (J.A. 643-644). Dr. Boehm's testimony was the only objective and credible

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[22] ***See*** footnote 13, ***supra*** at 28.

[23] Dr. Boehm has been repeatedly named one of the Best Doctors in America based on national peer recommendations. (J.A. 642-643). He was also named one of the Best Doctors For Women in the United States in August 1997 by Good Housekeeping Magazine. (J.A. 571). His medical specialty is obstetrics and gynecology with a subspecialty in maternal-fetal medicine. He is a Professor of Obstetrics and Gynecology at Vanderbilt Medical Center and is the Director of Obstetrics for the hospital. He is board certified in obstetrics and gynecology and in maternal-fetal medicine. (J.A. 563). Dr. Boehm has published over 120 articles, including an article on abortion risk factors. (J.A. 573-586). He has written three books and 24 book chapters. (J.A. 586-590).

expert testimony on this subject. Dr. Boehm also testified that where an unborn child has severe hydrocephaly, causing the head to be too large to pass through the cervix, he would use an ultrasound-guided cepholocentis procedure to "drain the ventricles of the amniotic fluid to allow the head to slip through the cervix." (J.A. 700-702). Dr. Boehm specifically testified that "We don't try to aspirate intracranial cerebral matter or brain matter." (J.A. 703).[24]

d. Partial-birth abortion/D&X is not safer than available alternatives.

As discussed above, a State may ban a particular abortion procedure where safe alternative procedures remain available. It is unnecessary, under this test, to ascertain the precise level of relative safety of each procedure (even if data was available to make such a determination). Nonetheless, the State wishes to address the incredible conclusion of the district court below that partial-birth abortion/D&X "is superior to, and safer than, the D&E and other abortion procedures." (Supp.App. 190). This conclusion is simply not supportable in light of the fact that only a handful of physicians in the entire country use the procedure even occasionally, and there are no studies showing its safety. The conclusion of the district court is particularly suspect in light of

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[24] The "head first" procedure discussed at great length by Dr. Stubblefield is not within the proscription of Nebraska's statute, and is therefore totally irrelevant. In this head first procedure, no part of a living child is delivered into the vagina before killing the child, let alone a substantial portion. (J.A. 279-281). Furthermore, as described by Dr. Stubblefield, the "headfirst" procedure was allegedly necessary to save the life of the mother. Such situations are covered by an express exclusion from Nebraska's statute.

the fact it goes beyond the position argued by the Plaintiff/Respondent at trial. This section will discuss the evidence before the Court on the issue of the relative safety of the D&X procedure.

i. There are no medical studies showing the safety of the partial-birth abortion/D&X procedure.

The uncontroverted evidence before the Court is that there are no medical studies establishing the safety of the partial-birth abortion/D&X procedure. Dr. Frank Boehm, who is an expert in the field of abortion (J.A. 561-598), testified that the safety of the D&X procedure has never been medically proven and that he is not aware of any ongoing studies in this area. (J.A. 630). This fact was also confirmed by the Respondent's witness, Dr. Phillip Stubblefield (J.A. 308, 310-311), as well as Stanley Henshaw (J.A. 18). The absence of such evidence is legally devastating to the Respondent's case, especially in light of the deference owed to state legislative enactments by federal courts. ***See Hope Clinic,*** 195 F.3d 857.

ii. There are no medical studies comparing the safety of partial-birth abortion/D&X to other abortion procedures.

The uncontroverted evidence before the Court is that there are no medical studies comparing the safety of partial-birth abortion/D&X to other abortion procedures.

The Respondent's own witness, Dr. Stubblefield, admitted at trial that there are no medical studies that compare the safety of the D&X abortion procedure with other abortion procedures. (J.A. 308). Dr. Stubblefield acknowledged that "the safety of the intact D&X procedure" has never "been studied to the point that it has been medically-accepted fact that it is a safer abortion procedure." (J.A. 310-311).

Likewise, Dr. Boehm testified as follows: "There's never been to my knowledge any studies that have compared the trauma to a woman's uterus, cervix, or other vital organs with either [the D&X or D&E] technique." (J.A. 628). "No studies have been done to show [relative safety] . . . one compared to another." (J.A. 634). "[N]o one has ever done any research on partial-birth abortion and compared it to other procedures." (J.A. 704).

e. A ban on partial-birth abortion/D&X would create no risk to the health of women.

The testimony of medical experts in this case shows that a ban on partial-birth abortion would create no risk to the health of women. The State's lead witness was Dr. Frank Henry Boehm.[25] Dr. Boehm is a medical expert on abortion procedures, and is staunchly "pro-choice." (J.A. 620) ("I have not wavered in my advocacy of the pro-choice movement."); (J.A. 661) ("I want in no way to erode further the ability of women to obtain a safe abortion. And that would include all the procedures . . . other than the intact D&X."). He is a significant financial contributor to Planned Parenthood. (J.A. 645). He has performed abortions in a clinic setting and also at Vanderbilt Medical Center. (J.A. 622). Dr. Boehm continues to do second trimester abortions on a regular basis, including abortions involving congenital anomaly where there are "serious malformations of the fetus." (J.A. 621).

Dr. Boehm is currently conducting fetal research, and has even done a video on ACOG forceps guidelines. (J.A. 598). He received no pay for his testimony. Unlike any other witness for either party, this witness has no self interest in the proceeding and is not philosophically aligned with the party for whom he testified or any organization aligned with such party. In fact, he is the

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[25] *See* footnote 23, ***supra*** at 37.

only witness with a contrary position on abortion to the party calling him as a witness. The Court could not ask for a more qualified, credible medical expert in this area than Dr. Boehm.[26]

In addition to Dr. Boehm, the State presented testimony from another highly-qualified OB-GYN. Dr. Christopher Riegel is a Diplomat of the American Board of OB-GYN and an obstetrician, gynecologist, and infertility specialist in Dallas, Texas (J.A. 164). Dr. Riegel was trained in a four-year internship and residency in Obstetrics and Gynecology at Parkland Hospital in Dallas at the University of Texas, Southwestern Medical School. This program is considered one of the top OB-GYN programs in the United States. (J.A. 164). In fact, this is where Williams Obstetrics is published. (J.A. 220). Although the district court concluded that it did not initially find some of Dr. Riegel's testimony "credible," later testimony, including some by the Respondent's own witnesses, as well as Dr. Boehm, independently confirmed his testimony.[27]

Dr. Boehm testified that he does not know of any situations "in which an intact D&X abortion procedure

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[26] In contrast, the Respondent in this case performs abortions in a clinic setting. (J.A. 30). He is not Board certified. (J.A. 82-83). He is not an OB-GYN. In fact, he doesn't even have hospital privileges. (J.A. 83-84).

[27] The only exception was Dr. Riegel's testimony regarding the safety of the head piercing procedure. However, the Respondent's witness on this issue also testified that he had not performed the procedure nor seen it performed. (J.A. 324). Thus, the district court simply had conflicting testimony on this point. Dr. Riegel's testimony regarding the "non-existence" of the partial-birth abortion/D&X procedure in medical texts (J.A. 220) was confirmed repeatedly by other witnesses, and the State remains mystified by the district court's seeming ridicule of Dr. Riegel on this undisputed point. *Carhart*, 972 F. Supp. at 518-519 (Supp.App. 45).

would be a safer abortion procedure for a woman" than the alternative procedures. (J.A. 634). He further testified that *"the banning of the partial-birth abortion as defined by LB 23," would not create "any adverse medical risk to the health of any woman seeking an abortion."* (J.A. 636) (emphasis added). He further testified that the reason such a ban would create no adverse medical risk to the health of any woman seeking an abortion is that "there are safe alternatives," including inductions with prostaglandin, and also D&E abortions. (J.A. 636). Significantly, Dr. Boehm testified that a *nearly identical statute in effect in his state of practice does not affect his "ability to perform medically safe abortions."* (J.A. 636-637). ***See*** Brief of Amicus Curiae Family First (data from States where partial-birth abortion statutes are in effect showing no impact on D&E or other abortion methods). ***See also Hope Clinic,*** 195 F.3d at 870 ("Thirty States enacted laws forbidding most partial-birth abortions. Judges prohibited the application of these laws in two-thirds of these States. In the other third the statutes have been in force. One way to perform a reality check on . . . [whether] these statutes cover only the D&X is to see what has happened in the States where the laws have been permitted to take effect.").

Dr. Boehm further testified that "the legislative ban on partial-birth abortion as defined by [Nebraska's Statute]" would not cause a woman seeking abortion to have to undergo an "alternative procedure which would create a higher risk of harm to her uterus, cervix, or internal organs." (J.A. 641). When asked why, he responded "for a variety of reasons. One is that we've been performing abortions for years on women safely with other techniques, and we don't have any data that would say that another technique such as partial-birth abortion is any safer." (J.A. 641). Dr. Boehm also specifically addressed the extreme case scenarios put forth by the Respondent. (J.A. 642-644) ***See*** discussion, ***supra*** at 37-38.

Dr. Boehm's testimony is even more compelling when one considers that the evidence before the Court

conclusively establishes that partial-birth abortion/D&X is an unpredictable procedure at best when performed by Dr. Carhart. Dr. Carhart testified the procedure fails to produce an intact extraction 90-95% of the time. (J.A. 61). Therefore, most of the time the Respondent fails to obtain intact extraction and must use standard D&E procedures anyway. Even in cases where it is successfully performed by Dr. Carhart, many of the same procedural methods of a D&E are still utilized. Dr. Carhart testified that following removal of the unborn child from the uterus, vacuum aspiration is performed within the uterus, and also "sharp curettage" is performed "to clean the uterus." (J.A. 45).

The testimony given by the State's expert medical witnesses is reliable and consistent with the views of other credible experts on the subject. Where a State adopts a statute patterned after federal legislation, it is appropriate for courts construing the state legislation to seek guidance from the federal legislative history developed by Congress. This is particularly appropriate in the present case since Nebraska's partial-birth abortion statute is nearly identical to that considered and passed overwhelmingly by both Houses of Congress. The extensive legislative history of the federal legislation demonstrates that the witnesses and evidence presented by the State of Nebraska are credible, and that their testimony is consistent with the view of most of the medical community, including some prominent abortion practitioners.

The Congressional legislative history of the "Partial-Birth Abortion Ban Act of 1995," HR 1833, 105th Cong. (1995) (as well as for the 1996 & 1997 legislation), contains extensive testimony regarding the safety of partial-birth abortion. The testimony shows (as confirmed by the evidence before this court) that "claims of safety are not substantiated," and "data for a safety evaluation is not available." ***Id.*** at 180. Other medical testimony was presented that there is no medical reason to ever use the procedure. ***Id.*** at 233.

Dr. Warren Hern, a "leading practitioner of late-term abortions and author of the most widely used textbook on abortion standards and procedures," *id.* at 356, was quoted, in Congressional testimony, that *"he could not imagine a circumstance in which this procedure would be safest."* *Id.* (emphasis added). Testimony from Dr. Pamela Smith, Director of Medical Education in the Department of Obstetrics and Gynecology at Mt. Sinai Hospital in Chicago, testified that "the only interest served by the partial-birth abortion procedure is the 'convenience' of the abortionist." *Id.* at 357. Consistent with the evidence before the Court in this case, Dr. Nancy Romer is quoted as stating "there is simply no data anywhere in the medical literature in regards to the safety and efficacy" of partial birth abortion. *Id.* at 357. Thus, the legislative history of the federal legislation shows that the testimony of the State's witnesses is reliable. In sum, a ban on partial-birth abortion/D&X would create no risk to the health of women.

f. The testimony offered on behalf of Respondent Carhart as to the safety of partial-birth abortion/D&X is unreliable and inconclusive.

In contrast to the testimony of the State's witnesses, the testimony of the Respondent's witnesses appears consistent with only a relative handful of physicians. The testimony offered on behalf of Dr. Carhart as to the safety of partial-birth abortion is unreliable and inconclusive. For example, Dr. Stubblefield's testimony on the comparative safety issue is simply not credible. He claimed (using speculative terms such as "theoretically" and "it makes sense") that the D&X is safer than the D&E procedure due to less instrumentation. (J.A. 276). Yet, he then testified that in his own practice he plans "to extend our D&Es to 20 weeks" and "stop doing" induction abortions during this period. (J.A. 294). This is inconsistent. If increased instrumentation was really a health risk, he

would not be preparing to take the opposite action. This is especially revealing in light of the fact that modern induction procedures are not otherwise considered less safe than D&Es.[28] His motivation was admittedly "cost saving" and "convenience." (J.A. 294). Similarly, Dr. Carhart (who insists the D&X procedure is performed to benefit the mother) testified that he never bothers to convert the child to a footfirst position to facilitate use of the procedure, but rather just takes the body however it presents itself. (J.A. 56) ("I just attempt to bring out whatever is the most proximal portion of the fetus."). If the health benefits of the procedure are really as he claims, this is illogical and inconsistent. Perhaps it is a tacit admission that deliberate breech delivery is, in fact, a health risk.

Finally, and perhaps most importantly, the Respondent presented no statistical evidence or data of any kind showing that partial-birth abortion/D&X is a medically safer procedure than alternative procedures. In fact, the record shows that reliable complication rates associated with various procedures and by gestational age are simply not available. (J.A. 1153). Therefore, data is not available to support "any firm conclusions about the relative safety of procedures." *Id.*

g. In the absence of objective and conclusive research data, the safety of medical procedures for purposes of state regulation of the medical profession is a state legislative determination which should not be disturbed by federal courts.

The Court should defer to the judgment of the state legislative branch on the relative safety of medical procedures in the absence of clear, definite and compelling evidence establishing that the legislative determination is

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[28] *See* footnote 21, *supra* at 36.

unreasonable. *Jones v. United States*, 463 U.S. 354, 365 n.13 (1983). Where, as here, no medical data is available to support the Respondent's assertions, and where opinions by medical witnesses are in disagreement, the decision regarding the regulation of medical procedures should be left to the state legislature. In such circumstances, the Court should defer to the state legislative body as a matter of federalism and separation of powers. In short, a federal court should not substitute its judgment about medical issues for that of a state legislature where the plaintiff fails to present objective and conclusive research data supporting his assertions.

The Nebraska Legislature, following the lead of Congress, and relying on medical opinion that the partial-birth abortion/D&X procedure is medically unnecessary and of untested or questionable safety, voted nearly unanimously to ban its use.[29] When the legislation was challenged in district court, medical experts disagreed as to the safety of the procedure, but concurred that no medical studies exist on the subject. Under such circumstances, it is evident that the judgment of the legislature on the issue was not unreasonable. Furthermore, the collective judgment of the State's elected legislators is just as legitimate as the opinion of one federal district judge. In such cases deference should be given by this Court to the Nebraska Legislature rather than to the single federal judge (even as affirmed by an appellate panel using a clear error standard of review). This is a practical necessity unless single federal judges are to decide the scope of medical practice in each state – potentially in divergent ways in each one.

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[29] The district court expressly acknowledged that legislators thought the procedure was unsafe. (R.Tr. 14) (Eighth Cir. App. 282) ("I think it is the State's view . . . that it is not an accepted procedure, and as a matter of fact, it's more dangerous. Certainly that's what some of the legislators thought.").

Deference to legislative fact finding under such circumstances is not a new or unfamiliar legal proposition to the Court. ***See Kansas v. Hendricks,*** 521 U.S. 346, 360 n.3 (1997) ("it is precisely where such disagreement [among medical professionals] exists that legislatures have been afforded the widest latitude in drafting . . . statutes."); ***Jones v. United States,*** 463 U.S. at 365 n.13 ("The lesson we have drawn is not that government may not act in the face of this [scientific] uncertainty, but rather that courts should pay particular deference to reasonable legislative judgments."); ***Marshall v. United States,*** 414 U.S. 417, 427 (1974) ("[M]edical uncertainties afford little basis for judicial responses in absolute terms.").

As the Seventh Circuit stated in ***Hope Clinic v. Ryan,*** "The question in the end is not what one or another judge found on a given record; it is whether the state legislatures exceeded their constitutional powers. Factual premises underlying legislation normally are not subject to review by trial courts." ***Hope Clinic v. Ryan,*** 195 F.3d at 872. "[I]t is significant that *none of the Supreme Court decisions in abortion cases suggests that the same law would be constitutional in one state, and unconstitutional in another, depending on a district judge's resolution of factual disputes.*" ***Id.*** at 873 (emphasis added). Even the dissenting judges in ***Hope Clinic*** stated that "the health effects of 'partial-birth' abortion . . . should indeed be treated as legislative fact rather than an adjudicative fact, in order to avoid inconsistent results arising from the reactions of different district judges, sheltered by the deferential 'clear error' standard of appellate review of fact findings, to different records." ***Hope Clinic,*** 195 F.3d at 884 (Posner, dissenting).

In the present case, since objective and conclusive evidence supporting the Respondent is absent, the legislative determination regarding the D&X procedure should not be disturbed by the Court.

3. The Effect of Nebraska's Statute Is to Serve Legitimate State Interests Which Do Not Strike at the Right to Choose an Abortion.

As shown above, Nebraska's partial-birth abortion statute does not have the effect of placing a substantial obstacle in the path of a woman seeking an abortion. Rather, the effect of Nebraska's statute is to serve legitimate state interests which do not strike at the right to choose an abortion. The legitimacy of the state interests stems from two basic facts. First, partial-birth abortion is performed only on late-term developing children. The procedure is usually performed in the days and weeks just prior to viability (if not after).[30] At this time, the State's interest in the life of the unborn child is at or near its zenith. The State's interest is so strong that the State is just short of being able to completely ban nontherapeutic abortions. ***Roe v. Wade***, 410 U.S. at 164-165 (the State's interest "grows in substantiality as the woman approaches term"). Second, the subject of the procedure is mostly outside of the womb. This fact is significant since ***Roe*** and ***Casey*** dealt only with "the unborn."

Under *Casey*, the State's interests need not be "compelling." Nonetheless, the State of Nebraska has important, if not compelling, interests which underlie its statute and which are served by the ban on partial-birth abortion. The statute has the effect of serving the State's interests in "show[ing] concern for the life of the unborn," and, more specifically, for the partially-born. ***Casey***, 505 U.S. at 869. It also serves the State's interest in preventing cruelty to partially-born children and "unacceptable disrespect for potential human life," ***id.*** at 914 (Stevens, J., concurring). The statute also serves the State's interest in preserving the integrity of the medical profession. ***Washington v. Glucksberg***, 521 U.S. 702 (1997); (J.A. 640). ***See also Doyle***, 162 F.3d at 478 (Manion,

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[30] ***See*** footnote 16, ***supra***, at 32.

J., dissenting) ("The State's interest in potential life, in regulating the practice of medicine and in the moral underpinnings of state law are legitimate and form a solid basis for the State enacting a statute to ban D&X abortions.").

The State has a substantial interest in protecting or at least showing concern for a child in an induced birth process. In the D&X procedure, the child is more outside the womb than inside. They are no longer "unborn." Furthermore, the State has a compelling interest in erecting a barrier to infanticide. Partial-birth abortion blurs the distinction between abortion and infanticide. This is undoubtedly why thirty state legislatures and both Houses of Congress (with the support of large numbers of pro-choice legislators) reacted so decisively to ban a procedure that is performed on late-term infants and which looks, to many, like infanticide.[31]

CONCLUSION

Nebraska's ban on partial-birth/D&X abortion can reasonably be construed as not encompassing the more common D&E abortion procedure, thereby leaving women a safe alternative procedure and avoiding the creation of an undue burden on the right to choose whether to terminate a pregnancy. In accordance with

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[31] These interests are undiminished, indeed unaffected, by the fact the statute does not "forbid the destruction of any class of fetuses," nor by the fact it does not ban all cruel forms of abortion, as posited by the dissenters in ***Hope Clinic***, 195 F.3d at 878. For example, in ***Ashcroft***, 462 U.S. at 486, the Court upheld a second-physician requirement even though live births were unlikely. Similarly, the State's interest in the life of the unborn child is still legitimate here (even though live delivery is not always, or even frequently possible) since live delivery is sometimes possible. (J.A. 49) (Carhart testimony that "If you have adequate dilation, yes, the skull can fit through the cervix.").

cardinal rules of construction and fundamental principles of federalism, and in recognition of the State's legitimate interests, the Court should reverse the decisions below and affirm the authority of the Nebraska Legislature to ban the partial-birth abortion/D&X procedure.

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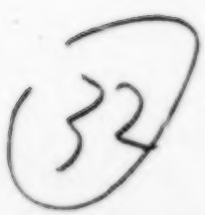

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IN THE

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska; GINA DUNNING, Director of Regulation and Licensure of the Nebraska Department of Health and Human Services; and CHARLES ANDREWS, M.D., Chief Medical Officer of the State of Nebraska,

Petitioners,

—v.—

LEROY H. CARHART, M.D.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether the Nebraska partial-birth abortion statute violates women's right to privacy because it bans a broad range of abortion procedures, including the safest method of second-trimester abortion, without regard to fetal viability?

2. Whether the court of appeals properly declined to narrow the scope of the Nebraska partial-birth abortion statute because doing so would have required the court to rewrite the law contrary to legislative intent and because such a narrowing construction would not cure its constitutional deficiencies?

3. Whether Nebraska's partial birth abortion statute violates women's right to privacy even if narrowed to ban only intact dilation and extraction abortions because it: (a) deprives women of their right to bodily integrity by forcing them to undergo undesired and unnecessary medical procedures and preventing some of them from undergoing the safest method of abortion; (b) has the effect of imposing an undue burden on women seeking pre-viability abortions by threatening their health without serving any legitimate state interest; (c) has the impermissible purpose of elevating legal protection of the fetus to the detriment of women's health and liberty; and (d) lacks any exception for women who require abortions to preserve their health, and contains only an inadequate life exception?

4. Whether Nebraska's partial birth abortion statute is void for vagueness because it uses terms such as "substantial portion" that fail to give physicians adequate notice of the prohibited conduct and invite arbitrary and discriminatory enforcement?

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STATEMENT OF THE CASE

A woman's right to terminate her pregnancy is firmly rooted in the Constitution, as this Court recognized in *Roe v. Wade*, 410 U.S. 113 (1973), and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). Moreover, *Roe*'s essential holding that a woman may terminate her pregnancy prior to viability has repeatedly been affirmed by this Court.

The Petitioners ("the State") seek to alter radically these basic tenets. In sweeping language, the Nebraska "partial-birth abortion" ban prohibits most modern abortion techniques without regard to viability of the fetus. *See* Neb. Rev. Stat. §§ 28-326(9), 28-328(1)-(4) ("the Act"). Indeed, the term "partial-birth abortion" was specifically designed to overturn *Roe* by luring this Court away from the viability polestar of its abortion jurisprudence. The Act is part of a coordinated national campaign to expand state interests in pre-viable fetal life at the expense of women's health and liberty.[1] It attempts to eviscerate women's privacy rights by making the location of the fetus in the woman's body -- not

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[1] All available evidence refutes the State's assertion that the public supports the nationwide campaign to ban "partial-birth abortions." In all three states where "partial-birth abortion" bans were submitted for approval in referenda, the bans were rejected by the people. *See* Martin Kasindorf, *No Broad Pattern Evident in Ballot-Initiative Results*, USA TODAY, Nov. 4, 1999, at 4A (Maine); Patrick O'Driscoll, *Voters Had Their Say in 44 States*, USA TODAY, Nov. 5, 1998, at 8A (Colorado and Washington). Fortunately, of course, constitutional rights do not depend on public opinion polls. *West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624, 638 (1943) (purpose of constitutional rights is "to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts.").

viability -- the defining criterion for women's pregnancy choices.[2]

Since *Roe*, legal abortion has had an enormous positive effect on women's health in this Nation, both because of the development of increasingly safe abortion techniques and because the abortion choice has been available to women who would otherwise be forced to carry unwanted high-risk pregnancies to term. It has become increasingly difficult, however, for women to obtain abortions. Physicians, like Respondent Carhart, have been forced to work in an exceedingly hostile climate, created not only by private individuals, but also by legislatures that repeatedly enact anti-abortion legislation without regard to women's health or this Court's abortion jurisprudence. *Hope Clinic v. Ryan*, 195 F.3d 857, 879 (7th Cir. 1999) (Posner, C.J., dissenting) *mandate stayed*, No. 99A428 (Stevens, Circuit Justice, Nov. 30, 1999). The record in this case establishes that the Act is a deceptive maneuver in the campaign to erode women's right to choose abortion.

I. THE NEBRASKA BAN

The Act bans "partial-birth abortions." It defines this term to mean "an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the child and completing the delivery." Neb. Rev. Stat. § 28-326(9).[3] The Act further

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[2] *See, e.g.*, James Bopp, Jr. and Curtis R. Look, *Partial Birth Abortion: the Final Frontier of Abortion Jurisprudence*, 14 ISSUES L. & MED. 3 (Summer 1998) ("As the [fetus] moves out of the womb it is clothed in personhood by proclamation of the U.S. Supreme Court."). State counsel of record contends that "abortion jurisprudence is limited in applicability to children in utero." Steven Grasz, *If Standing Bear Could Talk . . . Why There is No Constitutional Right to Kill a Partially-Born Human Being*, 33 CREIGHTON L. REV. 23, 26-27 (Dec. 1999).

[3] Although the statute does not define "unborn child," "pregnant" means "that condition of a woman who has unborn human life within her as a result of conception." Neb. Rev. Stat. § 28-326(4). Further, "conception" is defined as "the fecundation of the ovum by the spermatozoa." Neb. Rev. Stat. §28-326(5).

states: "the term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." *Id.*

The Act contains no exception for abortions performed to protect a woman's health, nor an exception for when a particular method or variation is the safest for a particular woman.[4] The Act contains only a limited exception for abortions performed to save a woman's life; it permits such procedures only where "necessary" to save her life and then only if the woman's life is threatened by a physical condition. Neb. Rev. Stat. § 28-328(1). By contrast, Nebraska's statute prohibiting post-viability abortions contains exceptions for the woman's life or health with no qualifiers, *see* Neb. Rev. Stat. § 28-329, and permits women requiring such abortions to use the safest method, *see* Neb. Rev. Stat. § 28-330.[5]

The penalty for violating the Act is a maximum prison term of 20 years with up to $25,000 in fines. Neb. Rev. Stat. §§ 28-328(2), 28-105. The Act also provides that a physician's medical license may be revoked for performing a prohibited procedure. Neb. Rev. Stat. § 28-328(4). These

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[4] The legislature failed to pass two amendments that would have permitted women whose health was at risk to undergo a banned procedure. Joint Appendix ("J.A.") 344-47, 405, 415.

[5] In fact, the life exception contained in Nebraska's pre-*Roe* criminal abortion statute did not exclude situations where the woman's life was threatened by a mental condition; and once a woman's life was in danger, physicians, not the legislature, determined the safest medical procedure. Former Neb. Rev. Stat. §§ 28-404, 28-405 (both repealed in 1973).

penalties far exceed those Nebraska applied to illegal abortions prior to *Roe*. Former Neb. Rev. Stat. §§ 28-404, 28-405 (both repealed in 1973) (from one to ten years imprisonment).

II. THE LEGISLATIVE HISTORY OF THE ACT

The Act's legislative history demonstrates that the Nebraska legislature was intent on adopting a broad ban on abortions. It did not aim to ban any specific abortion method; rather, its sponsors "tried to be as encompassing as possible." J.A. 478-79 (Hilgert).

The Act's chief sponsor, Senator Maurstad, acknowledged that it could operate in the first trimester of pregnancy. J.A. 447; *see also* J.A. 458-59 (Senator Bromm agreeing that bill is not a prohibition on late-term abortions). Moreover, Maurstad refused to equate "partial-birth abortion" with the "intact dilation and extraction" method of abortion, as the State now seeks to do in this Court. J.A. 380-83. Although Senator Maurstad repeatedly described his bill in specific terms, *see, e.g.*, J.A. 366 ("People know what 'partial-birth abortion' means. It's when . . . [e]very part of the child is outside the womb of the mother except for its head."), he conceded that the Act's language did not match his description.[6] J.A. 367. Later, however, Senator Maurstad admitted his description "was an accurate *example* of the definition provided in the bill," but "not the *only* example." J.A. 383 (emphasis added) (responding to questions by

[6] The sponsors of partial-birth abortion legislation in Congress also engaged in a similar "bait and switch" in which they described an abortion technique similar to one D&E variant, but then sent a "Dear Colleague" letter to other members of Congress explaining that the federal partial-birth abortion ban "would have the effect of prohibiting *any* abortion in which a child was partially delivered and then killed -- no matter what the abortionist decides to call his particular technique." A-1 (Exh. 31) (emphasis added).

Senator Chambers).[7] In fact, in opposing replacing the term "partial-birth abortion" with the term "intact dilation and extraction," J.A. 381, Senator Maurstad agreed that such an amendment would change "what the bill is designed to do." *Id.* Thus, the Nebraska legislature defeated an amendment that would have substituted the term "intact dilation and extraction" for partial-birth abortion. J.A. 404.

The Act's sponsors also consistently sought to extend legal protection to the fetus once any part of it was brought into the woman's vagina. Initially, the bill did not define the phrase "partially delivers vaginally." J.A. 417. Nevertheless, Senator Maurstad described the term "partially" in his bill as meaning "everything up to completely," or "the opposite of 'completely,'" and stated that "[t]here are many, many definitions of many examples that could fit in to the definition of 'partially'." J.A. 385. *See also* J.A. 367 (Maurstad) ("'partially delivered' . . . could be a foot"), 391 (Maurstad) ("partially delivers vaginally" means "not completely delivered from the vagina").

On the same day that a federal bill banning partial-birth abortion was modified in Congress, Senator Maurstad similarly amended the Nebraska bill to "define" "partially delivers vaginally" to mean "deliberate and intentional delivery into the vagina of a living child or a substantial portion thereof for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." J.A. 416-17.[8]

[7] Contrary to the State's position in this Court, *see* Brief of Petitioners ("Pet. Br.") at 20-21 n.7, Senator Maurstad stated that the Act prohibited not just the breech presentation abortion he had repeatedly described, but also a head first removal of the fetus. J.A. 437. *See also* J.A. 442-43.

[8] Congress amended the federal bill so that it would not extend to "what the doctor was doing when he was delivering the baby for the purpose of a live birth and is not doing an abortion." 143 Cong. Rec. S4671 (daily ed. May 19, 1997) (statement of Sen. Santorum). It did not amend the bill in order to narrow its application to abortion methods. *See Richmond*

This language was not intended to narrow the Act. After stating that the term "substantial" could be "easily defined and would not be something that would be necessarily contestable," J.A. 442, Senator Maurstad then stated: "one-third" of a fetus could be a substantial portion, J.A. 430; "one-fourth" *could* be, depending on "which fourth," J.A. 431; and "substantial would be subjective." *Id.* He also agreed that "as small a portion of the fetus as a foot would constitute a substantial portion," J.A. 452-53, as would a fetal hand. J.A. 453. Senator Maurstad plainly acknowledged that dismembering the fetus after "more than a little bit" of it had been delivered into the vagina would violate the Act. J.A. 442-43.

Other Senators were also confused by the term "substantial portion," although that did not deter their support for the Act. Senator Brashear believed that "substantial portion" connoted both "the portion of the body and . . . the function of that portion of the body," but he agreed that his gloss on the term was not in the bill. J.A. 443-44. He stated, "There's no question there will be a fact question as to what is a substantial portion." *Id.* at 444. Senator Abboud said: "I would assume . . . 'substantial' would mean a significant portion of that child"; he was unable to define the term further. J.A. 449. Senator Bromm, when asked if a physician reading the bill would understand what was meant by the words "or a substantial portion thereof," responded: "I think it would be difficult. . . . *I think their inclination would be simply not to take the risk.*" J.A. 456 (emphasis added). Senator Hilgert opined that the definition of "substantial portion" was "probably a litigable issue," and went so far as to state that if "several experts" on the state medical board "came up with very disparate conclusions upon what the

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Med. Ctr. for Women v. Gilmore, 55 F. Supp. 2d 441, 448 (E.D. Va. 1999) (discussing Santorum amendment), *stayed pending appeal without opinion*, No. 99-2000 (4th Cir. Sept. 14, 1999)

definitions [in the Act] referred to, . . . *that would, itself define ambiguity*." J.A. 475 (emphasis added).

III. STATEMENT OF FACTS

A. The Increasing Medical Safety of Abortion.

The nationwide legalization of abortion following *Roe* has resulted in dramatic health advances for women, and, as a consequence, there have been substantial decreases in the total number of abortion-related deaths and complications. Between 1973 -- the year *Roe* was decided -- and 1985, the death rate for abortion fell more than eight times, from 3.3 deaths per 100,000 in 1973 to 0.4 deaths per 100,000 in 1985. Council on Scientific Affairs, American Medical Association, *Induced Termination of Pregnancy Before and After Roe v. Wade*, 268 JAMA 3231, 3232 (1992). Similarly, abortion-related complications requiring hospitalization fell sharply during the 1970s, with the steepest drop following *Roe* in 1973. *Id.* at 3235.

Although medical advances have made abortions significantly safer for women, the unavailability of abortion providers is a continuing problem for women. In Nebraska, no hospital routinely performs abortions, S.A. 48-49;[9] J.A. 70 (Carhart), and, in 1996, there were only 8 physicians performing abortions in the entire state, down from 27 in 1979. J.A. 508, 527. Dr. Carhart is the only doctor in Nebraska who performs abortions after 16 weeks, S.A. 6, and his patients come from hundreds of miles away, J.A. 79 (Carhart).[10]

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[9] Citations to the Supplemental Appendix to the petition for certiorari, which reprints the district court's opinions, are given as "S.A."; citations to the appendix to the petition, which reprints the opinion of the court of appeals, are given as "_a"; and citations to the appendix to the brief in opposition to certiorari are given as "A-_".

[10] For example, one of Dr. Carhart's patients had been hospitalized with hyperemesis when she was 18 weeks pregnant. She had to be discharged

B. Abortion Methods.

Although the Act's prohibitions apply from the onset of pregnancy and without regard to viability, this case involves only the Act's application to the pre-viability abortions performed by Dr. Carhart. 7a; S.A. 5.

Abortion methods have evolved and changed since *Roe*. In 1975, saline instillation procedures accounted for 68-80% of all second trimester abortions. *Planned Parenthood v. Danforth*, 428 U.S. 52, 77 (1976). By 1983, however, this Court recognized that, due "principal[ly]" to the "wide[] and successful[] use" of the dilation and evacuation (D&E) procedure, in place of instillation techniques, "the safety of second-trimester abortions ha[d] increased dramatically," *City of Akron v. Akron Ctr. for Reproductive Health*, 462 U.S. 416, 435-36 (1983) (footnote omitted), to the point where the Court held that D&E procedures "may be performed safely on an outpatient basis in appropriate nonhospital facilities." *Id.* at 436.

Abortions today are performed by a number of methods. The specific method used depends on a variety of factors, including the stage of gestation, the individual woman's medical situation, and the training and skill of the physician. Abortion procedures can be placed in three general categories -- suction curettage, dilation and evacuation, and induction -- although physicians use variations and combinations of these procedures. *See Little Rock Family Planning Servs. v. Jegley*, 192 F.3d 794, 797 (8th Cir. 1999).

1. Suction Curettage

Suction curettage is by far the most common abortion procedure used in the United States, J.A. 488 (AMA); S.A. 7, as well as in Nebraska. J.A. 507. It is used up to about 15

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from the hospital and drive ten hours to Omaha in order to have a medically necessary abortion. She then had to drive ten hours back in order to be re-admitted to the hospital for continued treatment. *Id.*

weeks as measured from the first day of the woman's last menstrual period (lmp). J.A. 32 (Carhart), 262 (Stubblefield). In a suction curettage procedure, the physician dilates the woman's cervix using metal rods or osmotic dilators, inserts a tube (cannula) through the woman's vagina and into her uterus, and suctions the embryo or fetus and other products of conception through the woman's vagina and out of her body. J.A. 489 (AMA); S.A. 7-8. The physician sometimes also removes part or all of the fetus with forceps rather than suction. S.A. 8; J.A. 40 (Carhart); J.A. 262 (Stubblefield). After a portion of the fetus has been removed, other parts of the fetus remaining in the uterus will sometimes be alive. J.A. 258 (Stubblefield). The district court found that sometimes the embryo or fetus is brought into the vagina while it is still "living" and intact. S.A. 9, 28. Physicians know that suctioning a pre-viable fetus or embryo out of the woman's uterus will inevitably kill it. J.A. 99 (Carhart).

2. Dilation & Evacuation

Dilation and evacuation ("D&E") is the most common method of pre-viability second-trimester abortion, accounting for approximately 96% of all second-trimester abortions in the United States. J.A. 533 (CDC Table); S.A. 9.

The exact manner in which a physician performs a D&E varies depending on an individual woman's needs and on a physician's own preferences, as informed by his or her experience, skills and judgments about the woman's health. S.A. 6. A physician performing a pre-viability D&E procedure typically dilates the woman's cervix with osmotic dilators, and then removes the products of conception, including the pre-viable fetus, from her uterus using a combination of suction and forceps. J.A. 490 (AMA). In doing so, the physician typically inserts small forceps into the woman's uterus, grasps part of the fetus, and then pulls the pre-viable, living fetus into the vagina and then out of the

woman's body. J.A. 149 (Hodgson), 266-68 (Stubblefield). This process of delivering the fetus into the woman's vagina usually, but not necessarily, involves dismemberment of the fetus. J.A. 54-55, 61-62 (Carhart), 490 (AMA). Both courts below found that dismemberment of the pre-viable fetus does not occur in the woman's uterus. 9a; S.A. 12-13. The district court found that dismemberment occurs as a result of the traction caused by the removal of the fetus through the woman's cervical os into her vagina. S.A. 12. Once a portion of the fetus is removed out of the woman's body, the physician will reinsert the forceps into her uterus and repeat the procedure until all of the products of conception have been removed. J.A. 63 (Carhart), 149-50 (Hodgson), 266-67 (Stubblefield). Because one of the main complications in D&E procedures is uterine perforation, physicians always try to minimize the number of times forceps are inserted into the woman's uterus. S.A. 20, 29, 32.

After approximately 16 weeks gestation, the fetal head cannot typically be safely drawn through the woman's cervix unless it is compressed. J.A. 296 (Stubblefield).[11] In order to protect a woman's cervix, the physician either compresses the skull with forceps before pulling it into the vagina or removes the cranial contents. J.A. 48-50 (Carhart), 492 (AMA).

The "D&X" technique is a variant of D&E that has been developed to reduce risks to some women. S.A. 14.[12] In this D&E variation, the physician tries to remove the fetus intact

[11] It is not medically appropriate to dilate the woman's cervix to a greater extent than necessary to allow passage of the uncompressed head because doing so increases the risks of infection and bleeding. J.A. 297 (Stubblefield).

[12] Both the AMA and Dr. Stubblefield agree that the intact D&E or D&X method is a variation of the D&E procedure because it uses the same instruments and the same processes. J.A. 274 (Stubblefield), 492 (AMA Report refers to "a form of D&E that has been referred to in the popular press as intact dilation and extraction ('D&X')").

and collapses the fetal skull by suctioning the contents, rather than by collapsing it with forceps. S.A. 33; J.A. 492 (AMA). The D&X technique is the safest abortion for some women. S.A. 62-63; J.A. 492. Specifically, the district court found that Dr. Carhart's use of the D&X procedure is "appreciably safer than the D&E procedure" because:

> (a) it reduces instrumentation in the uterus that can cause damage to the uterus and cervix; (b) it reduces uterine or cervical perforation from bony fragments; (c) it prevents disseminated intravascular coagulopathy (DIC) and amniotic fluid embolus (among the most common causes of maternal mortality and complications); (d) it reduces the likelihood of retained fetal parts (a "horrible complication"); (e) it reduces the risk of "free floating head," an uncommon but significant complication; (f) because the D&X is less time consuming than dismembering the fetus, the woman has less operative time, which means less risk of hemorrhage, less total bleeding and less risk of infection when the procedure is used.

S.A. 62-63.[13] *See also* J.A. 492 (AMA), 600-01 (ACOG).

[13] The district court's findings are amply supported by the trial record. For example, the evidence adduced at trial demonstrates that D&X involves fewer insertions of instruments into the woman's uterus and therefore poses less risk of uterine perforation than other forms of the D&E procedure. J.A. 69, 121-22 (Carhart), 268, 275-79 (Stubblefield). Furthermore, because the physician removes the fetus intact in a D&X, the variant poses less risk of retained fetal tissue and uterine perforation by fetal bones than does a dismemberment-type D&E. J.A. 47-48 (Carhart), 268-69, 276, 297 (Stubblefield). The evidence also demonstrates that D&X poses less risks of certain rare complications, such as blood clotting abnormality and amniotic fluid embolism, than do other D&E procedures. J.A. 48 (Carhart), 269, 295 (Stubblefield).

The American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), and Dr. Phillip Stubblefield[14] agree that the D&X technique may be the best or most appropriate procedure to use in some situations. J.A. 284 (Stubblefield), 492 (AMA), 601 (ACOG). Based on a report summarizing the performance of approximately 2,700 D&Xs, Dr. Stubblefield believes that the D&X method has "a very impressive record." J.A. 276. While there are no formal medical studies comparing the safety of D&X to other abortion procedures, according to Dr. Stubblefield, "when one has discovered a way of doing something that is so much easier than what you're already doing, [then] it's kind of questionable whether you really need to go to that extent [*i.e.*, conducting studies]." J.A. 311.[15] Dr. Stubblefield further testified that advances in surgical procedures can become medically accepted prior to formal testing and medical proof of the procedure's benefits. J.A. 311-12. Accordingly, Dr. Stubblefield plans to use and teach the D&X method himself and has added the method to a chapter of a textbook he revises. J.A. 279, 307, 314.

Notwithstanding the lack of formal studies, the AMA refers to D&X, along with D&E, labor induction, hysterotomy and hysterectomy, as among "several alternatives that can be used to induce abortion" from the 16th to the 20th week of gestation. J.A. 491. Similarly,

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[14] Dr. Stubblefield, a physician who has been performing abortions since 1973, is a professor and chairman of the Department of Obstetrics and Gynecology at Boston University School of Medicine, and Director of Obstetrics and Gynecology at the Boston Medical Center.

[15] Given the violence that face doctors, it is not surprising that there have been no published studies regarding the comparative safety of D&X. In one case, due to fear of reprisals, a highly respected obstetrician-gynecologist who performs D&X was permitted to testify from behind a screen as a "John Doe" expert. *See Evans v. Kelley*, 977 F. Supp. 1283, 1287 n.4 (E.D. Mich. 1997).

ACOG, which has drafted a definition of D&X, recognizes that D&X is "one method of terminating a pregnancy [after 16 weeks]." J.A. 600. The State's expert concedes that studies are not a necessary prerequisite for the successful development of safer medical procedures. *See* J.A. 669, 675-76 (Boehm) (testifying he had switched from using saline to prostaglandin abortion without any medical studies); *see also* J.A. 530 (Nebraska abortion reporting form allows physician to report the procedure used as, *inter alia*, D&X).

3. Induction

Induction is the only other commonly used second-trimester abortion procedure, accounting for approximately 4% of such abortions nationwide. J.A. 484, 488 (AMA). If induction abortions have been performed in Nebraska at all in recent years, they amount to fewer than 1% of all abortions. J.A. 507 (Table 5). The induction procedure is essentially a pre-term induced labor in which the woman has contractions and eventually, after 15 or more hours, expels the pre-viable fetus. J.A. 272-73 (Stubblefield), 696 (Boehm).

Inductions are usually performed in hospitals, cannot be performed prior to 16 weeks lmp, and are medically contraindicated for women with certain medical conditions such as hypertension, heart disease, or diabetes. J.A. 24-25 (Henshaw), 70-71 (Carhart), 143 (Hodgson), 274 (Stubblefield), 492-93 (AMA). Some inductions may end up as D&E procedures, including the D&X variant. J.A. 71 (Carhart). Up to at least 21 weeks gestation, D&E is statistically safer than induction. J.A. 495 (AMA).[16]

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[16] Two older forms of abortion are hysterotomy and hysterectomy, which are rarely used today. Hysterotomy is a pre-term caesarian section. Hysterectomy is the removal of the uterus. Both are significantly riskier in terms of a woman's mortality and morbidity than other abortion procedures, including D&E and its variations, and are not acceptable abortion procedures. J.A. 281-82, 291 (Stubblefield), 493-494 (AMA).

C. Respondent's Practice.

Respondent Carhart is a retired Air Force Lieutenant Colonel who was on active duty for 21 years. S.A. 2. He has been a doctor since 1973 and has practiced in Nebraska since 1978, when he was assigned to the Offutt Air Force Base in Omaha. S.A. 2-3, J.A. 29-30 (Carhart). He served as Chairman of the surgery department at the base, supervising over twenty doctors, including obstetricians and gynecologists. S.A. 2-3.

Dr. Carhart performs abortions from 3 weeks lmp to viability. S.A. 5; J.A. 31, 76. Because no hospitals openly provide abortions in Nebraska, S.A. 48-49, and because he is the only physician in the state who performs abortions past 16 weeks lmp, Dr. Carhart's patients include women whose lives and health are at risk or whose fetuses have severe anomalies. S.A. 6; J.A. 76, 78-79 (Carhart). For example, his patients include women with severe renal failure, severe brittle diabetes, and women whose lives are in jeopardy and are referred to him by the University of Nebraska. S.A. 6; J.A. 78 (Carhart).

In treating his patients, Dr. Carhart chooses the most appropriate abortion method based on contemporary medical standards and evolving safety criteria. S.A. 6; J.A. 32. In all abortions after 15 weeks, Dr. Carhart attempts to perform a D&X because it poses less risk of both mortality and morbidity than other D&E procedures. S.A. 15; J.A. 46-48, 54, 61.[17]

Because both involve abdominal removal, rather than vaginal delivery, of the fetus, neither of these riskier methods is affected by the Act.

[17] The district court found that, in 1996, Dr. Carhart performed 800 abortions, 200 of which were performed at 14 weeks gestation or greater. S.A. 5-6. Dr. Carhart is able to remove an intact fetus from a woman's body in five to ten percent of the abortions in which he attempts it. J.A. 61.

To perform a D&E up to 20 weeks, Dr. Carhart uses suction or forceps to rupture the membranes. J.A. 46. Then, using forceps, Dr. Carhart attempts to draw the pre-viable fetus into the woman's vagina until the fetal skull lodges in the uterine side of the cervical os. J.A. 56-58. The fetus is typically and technically alive at this point since Dr. Carhart has not taken any step to ensure fetal demise. S.A. 13-14; J.A. 57.[18] Dr. Carhart uses ultrasound during all D&E procedures to minimize the possibility of any unnecessary trauma to the woman; thus, he is able to observe the pre-viable fetus and its heartbeat during the procedure. S.A. 11; J.A. 44, 46. Because he only performs pre-viability abortions, Dr. Carhart knows that every abortion he performs will cause fetal demise. J.A. 99.

Dr. Carhart is not always able to remove an intact fetus because, frequently, after the membranes are ruptured, a fetal extremity spontaneously protrudes into the woman's vagina. S.A. 11.[19] When this happens, Dr. Carhart grasps the extremity and pulls the fetus through the cervical os. S.A. 11. Even when a limb does not spontaneously protrude, the pre-viable fetus sometimes becomes dismembered by the traction of the fetus against the woman's cervical os while Dr. Carhart is drawing it into her vaginal canal. S.A. 12. Thus, when dismemberment occurs, it does so while the fetus

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[18] After 20 weeks, Dr. Carhart ensures fetal demise by injecting digoxin and lidocaine into the pre-viable fetus. J.A. 64. Such injections are riskier in the earlier stages of pregnancy due to the smaller size of the fetus. For example, as the district court recognized, an injection at an earlier stage of pregnancy could penetrate the woman's bowel or deliver the substance into the woman's circulation, yet it has no maternal health benefits. S.A. 18-19; J.A. 66-67, 129, J.A. 291-293 (Stubblefield). For some women, an injection is medically contraindicated. S.A. 19; J.A. 66-67, 113.

[19] While Dr. Carhart does not always successfully perform the D&X procedure (J.A. 61), this does not relieve him of liability under the Act, because attempting to commit a criminal act is a crime even if the crime is not successfully completed. *See* Neb. Rev. Stat. § 28-201.

is partially in the woman's vagina. S.A. 12-13; *see also* 9a-10a. Dismemberment of the fetus causes fetal demise. J.A. 62-64 (Carhart).

Because the skull is too large to pass safely through the woman's cervical os, Dr. Carhart either compresses the head of the pre-viable fetus with forceps or perforates the skull and uses a suction cannula to remove its contents. S.A. 17.[20] Like dismemberment, removing the contents of the skull also eventually causes fetal demise. S.A. 17 (district court noting that while brain death occurs "sometime" during cranial reduction process, fetal heart function "may continue for several seconds or minutes after the fetus's skull is decompressed."); J.A. 58-59. If the fetus presents itself head first, Dr. Carhart performs the procedure in reverse order by first decompressing the fetal skull while the body of the fetus is in the uterus. J.A. 48-49.

D. The State's Evidence.

The State produced no expert testimony that D&X is not safe; nor did the State produce any evidence that D&X is not an "abortion" procedure. In fact, the only State witness found credible by the district court, Dr. Boehm, supports the Act based on his understanding that it bans only the D&X technique, and then solely for political and personal reasons -- not because the D&X technique is unsafe. J.A. 635-36, 672-73. In fact, he conceded that D&X could well be safer than other D&E variants. S.A. 42. He also admitted that he was not as much of an expert on advances in the D&E procedure, since he has not performed such procedures in the past 10 to 15 years, J.A. 627, 654, 709, and that his idea that "partial-birth abortion" is the equivalent of D&X was gained from "the press," a source he would not ordinarily rely upon for formation of his medical opinions. J.A. 663-664.

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[20] Dr. Carhart testified that he dilates a woman's cervix enough to do the procedure, but no more than needed in order safely to remove the products of conception. J.A. 49 (Carhart).

Moreover, Dr. Boehm testified that without the "substantial portion" language, the Act would prohibit most D&E procedures. J.A. 711. Though he testified that the phrase "substantial portion" means "a significant portion of the fetus," he admitted this "definition" was only his "own personal view and not necessarily the view of someone who wants to prosecute this letter of the law." J.A. 709-10. He further admitted that some people may interpret a "substantial portion" to mean a hand or leg and, given that interpretation, the Act proscribes the D&E procedure. J.A. 665-66, 709-10.[21]

IV. HISTORY OF THE PROCEEDINGS

On June 12, 1997, Dr. Carhart filed a complaint challenging the Act's constitutionality in the United States District Court for the District of Nebraska. J.A. 1. On July 2, 1998, the district court issued a preliminary injunction against enforcement of the Act as applied to Dr. Carhart and his patients. J.A. 1. On August 10, 1998, a final judgment was entered against the defendants permanently enjoining them from enforcing the Act against Dr. Carhart, his patients, and others similarly situated. J.A. 2. The district court held that the Act was broad enough to encompass all D&E abortions, and therefore imposed an undue burden; but that, even if it prohibited only certain D&X variants of the D&E, it banned abortion procedures that are the safest for some women and is therefore unconstitutional for this reason as

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[21] The State's other witness, Dr. Riegel, was found "generally not credible" as to abortion practice by the district court. S.A. 45. His wandering testimony about the meaning of the Act and its terms is, however, persuasive evidence of the Act's vagueness. He testified that "substantial portion" is "a vague term," J.A. 232, that it could mean 30% of the fetus, or 50% of the fetus, *id.*, or a "good part" of the fetus, J.A. 232-233, or "half to three-quarters" of the fetus, J.A. 235, and that "it might mean different things to different people." J.A. 234. He acknowledged, however, that he obtained his understanding of the Act's scope from "lay press." J.A. 218.

well. The district court further held that the term "substantial portion," essential to understanding the Act's scope, was void for vagueness. S.A. 86-87. The court of appeals affirmed unanimously, upholding all the district court's finding of facts, but reaching only the holding that the Act prohibits all D&Es and therefore imposes an undue burden. 18a-19a.[22]

SUMMARY OF THE ARGUMENT

Nebraska's ban on "partial-birth abortion" was enacted as part of a deceptive nationwide campaign to eviscerate the key protections guaranteed to American women by *Roe* and *Casey*. Contrary to the way the State characterizes the Act, its prohibitions are limited neither to one medical procedure nor to post-viability abortions. Rather, any reasonable construction of the plain language of the Act, underscored by its legislative history, establishes that the ban is so broad as to prohibit, at a minimum, the D&E method of abortion, the

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[22] Throughout the proceedings, the State has equivocated about whether the Act bans one specific procedure and, if so, whether it bans D&X as defined by ACOG, J.A. 599-600, or "variations" of some unknown number and kind. *See* Defs.' Opp. to Pls.' Mot. for Prelim. Inj. at 29. (July 15, 1997) ("[A]ny concerns about LB 23 possibly covering induction abortions are without merit. If a child is delivered alive by induction, an abortionist may not then kill the child even under existing law. If the child is partially delivered (alive) and then deliberately killed, the procedure would not be an induction, but rather a partial birth abortion. *See* LB 23, § 2(9)."); at 45 ("[T]he State of Nebraska, through the legislative process of its elected representatives, has prohibited *any* and *all* methods of killing a living fetus once it has been partially delivered into the vaginal canal regardless of whether the procedure is called 'intact D&E', 'D&X', or 'Sucking the Brains out of a Partially Born Living Baby.'"); at 45 ("The Legislature has prohibited any method of killing of living fetus once it has been partially delivered into the vaginal canal. Use of ACOG or other procedural definitions would allow easy avoidance of the statute since a slight alteration in sequence or procedure would technically not be an 'intact D&E', for example, as described by ACOG.").

most common second-trimester abortion method, as both courts below found. Such a broad ban on a safe and common method of abortion performed pre-viability is unconstitutional under the settled precedents of this Court.

Moreover, the Act is not reasonably susceptible to a construction that would limit it to any one well-defined abortion technique; any such construction would require unconstitutional rewriting of the Act and would conflict with the Act's legislative history. Nor would the State's proposed narrowing of the Act to ban only D&X abortions save it. Such a narrower ban would itself be invalid for three reasons. First, it would deprive women of their right to bodily integrity by forcing them to undergo undesired and unnecessary medical procedures and depriving them of access to the method of abortion that would be the safest in their own individual circumstances. Pregnant women seeking abortions should not be forced to endure such physically intrusive alterations in the medical procedures they are to undergo. These are intrusions no other group of persons would ever be expected to endure. Second, the narrower ban would have the effect of imposing an undue burden on women seeking pre-viability abortions because it would harm women's health without serving any legitimate state interest. In addition, it would have the impermissible purpose of according legal protection to the pre-viable fetus based on its location in the woman's body and at the expense of women's health and liberty. Third, it would be unconstitutional because it lacks any exception for women who require abortions to preserve their health, and contains only a grossly inadequate life exception.

Finally, the Act is void for vagueness. By using vague terms such as "substantial portion," the Act fails to give physicians notice of the conduct it prohibits and is an open invitation to arbitrary and discriminatory enforcement. Thus, it will chill the performance of all abortions.

ARGUMENT

I. THE ACT IMPERMISSIBLY PROHIBITS MOST ABORTIONS.

As both the district court and the court of appeals held, the Act prohibits common, safe abortion methods regardless of viability and is therefore unconstitutional. 18a-19a; S.A. 69-70, 74-75, 79. The State agrees that if the Act prohibits D&E abortions it is unconstitutional, so the State now seeks to limit the Act to a subset of D&E procedures it refers to as "D&X," but never defines.[23] But "partial-birth abortion," as defined by the Act and its legislative sponsors, is not the same thing as the D&X technique defined by ACOG and other medical organizations. On the contrary, the Act's definition of "partial-birth abortion" intentionally sweeps far beyond D&X.

Every court to review a partial-birth abortion ban on the merits has concluded that it bans more than D&X (by any definition), including, at a minimum, other forms of D&E. *Planned Parenthood v. Miller*, 195 F.3d 386, 388-89 (8th Cir. 1999), *petition for cert. filed*, 68 U.S.L.W. 3434 (U.S. Jan. 3, 2000) (No. 99-1112); *Little Rock Family Planning Servs. v. Jegley*, 192 F.3d 794, 797-98 (8th Cir. 1999); *Causeway Med. Suite v. Foster*, 43 F. Supp. 2d 604, 614-15 (E.D. La. 1999), *appeal argued*, No. 99-30324 (5th Cir. Mar. 2, 2000); *Richmond Med. Ctr. v. Gilmore*, 55 F. Supp. 2d 441, 471 (E.D. Va. 1999), *stayed pending appeal without opinion*, No. 99-2000 (4th Cir. Sept. 14, 1999); *Weyhrich v. Lance*, No. CV98-0117-S-BLW (D. Idaho Oct. 12, 1999); *Rhode Island Med. Soc'y v. Whitehouse*, 66 F. Supp. 2d 288, 309 (D.R.I. 1999), *appeal stayed*, No. 99-2095 (1st Cir. Nov. 22, 1999); *Planned Parenthood v. Verniero,* 41 F. Supp. 2d 478, 503-04 (D.N.J. 1998), *appeal argued*, No. 99-5042 (3d

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[23] Earlier in this litigation, the State argued *against* precisely such a limitation. *See supra* n.22

Cir. Nov. 19, 1999); *Eubanks v. Stengel*, 28 F. Supp. 2d 1024, 1035 (W.D. Ky. 1998), *appeal argued*, No. 98-6671 (6th Cir. Dec. 15, 1999); *A Choice for Women v. Butterworth*, 54 F. Supp. 2d 1148, 1155 (S.D. Fla. 1998), *appeal dismissed*, No. 99-4002 (11th Cir. Mar. 2, 1999); *Planned Parenthood v. Woods*, 982 F. Supp. 1369, 1378 (D. Ariz. 1997), *appeal dismissed*, No. 97-17377 (9th Cir. Feb. 26, 1999); *Evans*, 977 F. Supp. at 1317; *Planned Parenthood of Alaska v. Alaska*, No. 3AN-97-6019, slip op. at 17 (Alaska Super. Ct. Mar 13, 1998), *appeal docketed*, No. S-08610 (Alaska Apr. 13, 1998); *Intermountain Planned Parenthood v. Montana*, No. 97-477, slip op. at 12 (Mont. Dist. Ct. June 29, 1998). Even the one court to uphold partial-birth abortion statutes conceded that they can be read to prohibit both D&E and induction procedures and therefore ordered the issuance of "precautionary injunctions" to narrow their scope. *Hope*, 195 F.3d at 863, 869.

A. The Act's Plain Language Prohibits Most Abortions, and its Broad Scope is Confirmed by its Legislative History.

The cardinal principle of statutory construction in Nebraska law is to "give effect to the purpose and intent of the Legislature as ascertained from the entire language of the statute considered in its plain, ordinary, and popular sense." *State ex rel. Stenberg v. Moore*, 602 N.W.2d 465, 472 (Neb. 1999). Where the terms of a statute are open to interpretation, Nebraska law directs courts to look to legislative history. *Id.* at 473. Both the Act's plain language and its legislative history establish that it bans most abortion methods.

As the State has conceded, the crime of partial-birth abortion is composed of three elements: "the intentional 1) partial delivery of a living fetus vaginally, 2) killing the fetus and 3) completing the delivery." Defs.' Post-trial Brief at 93-94. These elements describe conduct that is intentionally

performed in almost all pre-viability abortion methods, including suction curettage, D&E (and its D&X variant), and induction. None of the elements is unique to D&X; instead, the Act's definition of "partial-birth abortion" describes the material elements common to all these methods.

First, in every pre-viability abortion performed by suction curettage, D&E (including its D&X variant), or labor induction, the physician deliberately and intentionally delivers the embryo or the fetus, or parts thereof, into the vagina. S.A. 79. In fact, it is the essence of all non-abdominal abortion methods that the pre-viable "unborn child" is delivered into the woman's vagina in order to be removed from her body. J.A. 289-90 (Stubblefield). Unless the physician takes steps to insure fetal demise before delivering part of the fetus into the vagina,[24] the "unborn child" will ordinarily be "living," even though not viable when the physician draws it into the vagina. J.A. 41-44, 47, 57 (Carhart), 290-91 (Stubblefield). Further, in any of these methods, the physician usually delivers part of the "living unborn child" into the vagina, J.A. 290-91 (Stubblefield), and the legislative history of the Act establishes that *any* part of the fetus constitutes a substantial portion. *See supra* at 6.[25] Additionally, the Act's plain language, confirmed by the legislative history, applies to the delivery of a substantial portion of the fetus regardless of whether that portion is still attached to an intact fetus.[26]

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[24] As set forth above, *see supra* at n.18, the district court found, and the State does not dispute, that prior to 20 weeks gestation inducing fetal demise only imposes increased health risks on the woman without conferring any corresponding benefit. S.A. 18-19.

[25] The State completely disregards this legislative history, *see* Pet. Br. at 21 n.7, arguing circularly that the term is defined by its "context" and means the entire "child up to the head." *Id.* at 20. Notably, this is a meaning of the term expressly rejected by the Act's sponsor. J.A. 367.

[26] Requiring the "substantial portion" to be a portion of an *intact* fetus, as the State suggests, Pet. Br. at 16, would require an improper judicial revision of the Act. *Virginia v. American Booksellers*, 484 U.S. 383, 397 (1988); *Reno v. ACLU*, 521 U.S. 844, 884-85 (1997). Further, in many abortions by suction curettage, D&E and induction, the physician does deliver the living fetus into the vagina while it is intact. S.A. 79; J.A. 42 (Carhart), 258 (Stubblefield).

Second, in every pre-viability suction curettage, induction, or D&E procedure, the physician has the purpose of performing a procedure that the physician knows will kill the fetus. J.A. 290 (Stubblefield). The Act does not require, as the State now urges, that the procedure that kills the fetus be "a separate death-causing procedure." *See* Pet. Br. at 14. Adding such a requirement would entail impermissibly rewriting the Act. *See American Booksellers*, 484 U.S. at 397; *ACLU*, 521 U.S. at 884-85. Even if the Act could be construed to contain such a requirement, however, most D&E and some suction curettage and induction procedures include a "death-causing procedure," be it dismemberment, cutting the umbilical cord, completely removing the fetus from the uterus with suction, or reducing the size of the fetal head so it fits through the cervix.[27]

Third, in each of these procedures, the physician, after having taken steps that he knows will kill the fetus, completes the delivery of the "unborn child." This involves removing remaining products of conception, including the placenta, with suction, forceps, or a combination of both. J.A. 44-45 (Carhart). Thus, the three elements of the crime are met in most abortions.

The Act's legislative history confirms its applicability to most pre-viability abortions. As one supporter stated: "We tried to be *as encompassing as possible*. . . . This bill does

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[27] The Act's sponsor explicitly stated that the Act prohibits D&Es in which the fetus is killed by dismemberment after partial delivery. J.A. 442-43; *see also* S.A. 83. Further, the State concedes that, in an induction: "If the child is partially delivered (alive) and then deliberately killed, the procedure would not be an induction, but rather a partial-birth abortion." Defs.' Opp. to Pls.' Mot. for Prelim. Inj. at 29 (July 15, 1997).

encompass more than specific examples [of D&X techniques] that people related and the illustrations presented. . . ." J.A. 478-79 (Sen. Hilgert) (emphasis added). Similarly, Senator Maurstad admitted that the D&X procedure he described "was an accurate *example* of the definition provided in the bill," but "not the *only* example." J.A. 383 (emphasis added) (responding to questions by Senator Chambers). In fact, the Legislature rejected an amendment to narrow the Act to prohibit only "intact dilation & extraction" procedures. J.A. 380, 404. In opposing this amendment, Senator Maurstad stated that the amendment would change "what the bill is designed to do." J.A. 381.

Thus, the Act's plain language and its legislative history demonstrate that the Act operates to ban most pre-viability abortions; certainly, the court below correctly concluded that it bans most D&Es. *See* 18a-19a. A ban on most pre-viability abortions is plainly unconstitutional under *Casey*, as is a ban on the most common method of second-trimester abortions. *Danforth*, 428 U.S. at 78-79. Further, any such ban also violates women's right to privacy for the same reason that a ban on a single abortion technique does. *See* Point II.

B. The Act is Not Reasonably Susceptible to Any Narrowing "Construction."

In an effort to salvage the Act, the State makes several overlapping arguments for limiting the ban to only D&X abortions. This Court can only adopt a narrowing construction of the Act if it is "reasonably susceptible" to that construction. *American Booksellers*, 484 U.S. at 397; *ACLU*, 521 U.S. at 884. Yet each rationale the State proposes for a statutory overhaul is unsupported by the record. Indeed, the proposed revisions contradict both the text of the Act and its legislative history. Moreover, several rationales violate the cardinal principle that, in Justice Frankfurter's words, "A judge must not rewrite a statute, neither to enlarge nor to

contract it." Felix Frankfurter, *Some Reflections on the Reading of Statutes*, 47 COLUM. L. REV. 527, 533 (1947).[28]

First, the State argues that the Act cannot be construed to prohibit D&Es (other than the D&X variant) because the State has never applied or threatened to apply the Act to those abortions. Pet. Br. at 12. But the State's failure to prosecute a D&E or any other abortion procedure during the eight-day period the Act was in effect provides no basis for narrowing the Act, particularly since Dr. Carhart did not provide abortions during that period. J.A. 120 (Carhart). Moreover, Dr. Carhart was under no obligation to wait and see which of his abortions would result in felony charges before challenging the Act. *See Doe v. Bolton*, 410 U.S. 179, 188 (1973). In light of the legislative history of the Act, and the fact that he was targeted by name in the sponsor's legislative file, J.A. 718, he would have been foolish to do so.

Second, the State argues that its "chief law enforcement officer" -- Petitioner Stenberg -- has "interpreted the statute as encompassing only the D&X procedure." Pet. Br. at 12. But the State cites only *arguments* made in the course of *this litigation* for this "interpretation." Such arguments do not amount to interpretation; indeed, if they did, the State could simply cite its own brief as an "interpretation" that is "entitled to deference." *See id.*[29] Moreover, the State's

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[28] For the same reason that the Act cannot be narrowed by judicial rewriting to cover only D&X abortions, the Seventh Circuit's narrowing of similar statutes by precautionary injunctions was a transgression of that court's authority. *See Hope*, 195 F.3d at 886 (Posner, C.J., dissenting) (observing that those injunctions "brushed aside" the limitations on federal court revision of state statutes).

[29] The State also asks this Court to defer to the Nebraska Attorney General's shifting "interpretation" of the Act during this litigation pursuant to a variation of the deference this court gives to federal agency interpretations of federal statutes under *Chevron v. Natural Resources Defense Council*, 467 U.S. 837, 844 (1984). *See* Pet. Br. at 28. But even

position on the meaning of the Act has shifted considerably during this litigation. *See supra* at n.22. The wide-ranging inconsistencies in the State's assertions about the Act's scope render its latest *ipse dixit* "interpretation" neither credible nor persuasive. Finally, Stenberg's "interpretation" is not binding on either Nebraska state courts or prosecutors. *State v. Coffman*, 330 N.W. 2d 727, 728 (Neb. 1983); *Follmer v. State*, 142 N.W. 908, 910 (Neb. 1913).

Third, under the rubric of examining the Act's plain language, *see* Pet. Br. at 13-21, the State claims that no reasonable person could understand "partial-birth abortion" to mean anything except D&X. This claim is refuted by: (1) the fact that the four "reasonable" federal judges below, as well as numerous other federal and state court judges, all concluded that the Act bans D&Es, *see supra* at 20-21; (2) the fact that the chief legislative sponsor of the Act stated that D&X is only one "example" of the procedures to which the Act applies, *see supra* at 4; (3) the concessions of the State's own witnesses, *see supra* at 17;[30] and (4) the State's previous descriptions of the Act's scope, *see supra* at n.22.

The State next asserts that the Act cannot reasonably be read to apply to "dismemberment" abortions because a fetus

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if *Chevron* deference applies to constructions by state agencies of state law, it is appropriate only where the agency interpretation is consistent with legislative intent. *Chevron*, 467 U.S. at 842-44. Here, no consistency between the Attorney General's latest "interpretation" and the intent of the Nebraska Legislature exists. Further, the Act does not charge the Nebraska Attorney General with "issu[ing] regulations implementing" the Act. *Olmstead v. L.C.*, 527 U.S. 581, 119 S. Ct. 2176, 2185 (1999).

[30] Dr. Boehm, described by the State as giving "the only objective and credible expert testimony" in this case, Pet. Br. at 37-38, conceded that, without the "substantial portion" language, the Act bans D&E abortions. J.A. 710-11. He also conceded that others could easily interpret the term "substantial portion" in a manner that would still result in the Act prohibiting the D&E method. J.A. 665-67, 709-11.

must be "intact." But the word intact appears nowhere in the Act;[31] indeed, the chief sponsor of the Act agreed that it could apply to procedures in which the fetus is dismembered after partial delivery. S.A. 83-85; J.A. 442-43. The State also proposes that this Court rewrite the phrase "for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child" to read "for the purpose of performing a *separate* death-causing procedure." Pet. Br. at 14 (emphasis added).[32] This proposed revision presents three problems: it requires the Court to amend the Act; it does not explain how a physician can determine which steps constitute "separate" procedures; it does not exclude D&E abortions because there is no principled distinction in terms of "separateness" between compressing the fetal head and dismembering the fetus.[33] Both cause fetal demise and

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[31] As both courts below found, in most D&E abortions, the fetus is intact when the physician draws it partway into the woman's vagina; only after it is "partially delivered" does dismemberment occur. 9a-10a; S.A. 12-13; J.A. 61-62 (Carhart). Further, nothing in the Act requires the fetus to be "intact" after the procedure is completed.

[32] Similarly, the State asks the Court to rewrite the phrase "and does kill the unborn child" to read "kill[s] the unborn child *by the separate procedure . . .*" *Id.* (emphasis added). Even if the Act were rewritten to require intentional delivery into the vagina for the purpose of performing a "separate death-causing procedure," it still would *not* require that this "separate death-causing procedure" be the action that kills the fetus. *Any* intentional act that "does kill the unborn child" after partial delivery is sufficient under the Act's plain language.

[33] Indeed, that neither dismemberment nor compressing the fetal head is a "separate" procedure is shown by the fact that no physician would ever perform it in isolation. The State claims a difference between dismemberment and compressing the fetal head based on the physician's knowledge of precisely when fetal demise occur. *See* Pet. Br. at 17-18. But the Act does not require such knowledge as an element any more than a homicide statute requires the murderer to know when his victim dies. Further, as the district court recognized, the exact timing of fetal demise is not known even in a D&X procedure. S.A. 17; J.A. 56-60.

are simply steps in the overall abortion procedure.[34] *See* sup*ra* at 16. Further, the State asks this Court to construe the term "substantial portion" to mean "the child up to the head," Pet. Br. at 20, claiming that this meaning is clear from the Act's legislative history. But the extensive discussions in the Nebraska Legislature establish that, whatever the Legislature intended this phrase to mean, it certainly did not intend it to mean "completely up to the head." J.A. 367.

Fourth, the State selectively quotes from the Act's legislative history to support its claim that the Act's "expressly stated [legislative] purpose" is to ban only the D&X procedure. Pet. Br. at 22-23. Any but the most cursory review of the legislative history, however, establishes that the Act's sponsors clearly intended a much broader prohibition. *See supra* at 4-7. They believed the Act applied in the first trimester. J.A. 447, 458-59. They believed the Act applied to procedures involving dismemberment. J.A. 443. They believed the Act was triggered when any part of the living fetus was brought into the vagina. J.A. 454. They sought to be as "encompassing as possible." J.A. 478. And they rejected an amendment that would have limited the ban to D&X abortions. J.A. 380, 404-05. Thus, the legislative history flatly contradicts the suggestion that the Act was intended to reach only D&X procedures.

Finally, the "doctrine of constitutional avoidance" advanced by the State, Pet. Br. at 23, does not authorize a federal court to rewrite a state statute. *American Booksellers*, 484 U.S. at 397. Moreover, resort to this "doctrine" would be futile here because the Act is unconstitutional even if

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[34] The State's contention that the physician does not "know" that dismemberment kills the unborn child, *see* Pet. Br at 18, is simply not credible. A D&E does not involve "random acts of dismemberment," *id.*; it involves intentional dismemberment of the fetus in as few steps as possible by drawing the fetus into the vagina and using the traction of the fetus against the cervical os to detach the part to permit safe removal. S.A. 12-13; J.A. 54-55, 61 (Carhart), 490 (AMA), 266-68 (Stubblefield).

rewritten to ban only some subset of abortions. *See* Points II & III *infra*.

Thus, the Act cannot reasonably be construed to prohibit only D&X. Because the Act bans most safe abortion methods, it is unconstitutional. *Danforth*, 428 U.S. at 78-79.

II. THE ACT, EVEN IF REWRITTEN, VIOLATES WOMEN'S RIGHT TO PRIVACY.

Even if the Act could be rewritten by this Court to ban only a subset of D&E abortions, such a narrower ban would still be unconstitutional because it would prohibit medically accepted abortion techniques that are the safest techniques for some women.[35] Moreover, there is no way to construe the Act to include a health exception or full-fledged life exception, as are required under this Court's precedents. Indeed, the State opposes such exceptions. Pet. Br. at 30-31. Furthermore, the State does not seriously contend that the Act serves its interests in maternal health or potential life -- it only serves "interests," which, if deemed legitimate in this context, would justify complete bans on all abortions.[36] *A fortiori*, the much broader ban imposed by the Act's plain language is also unconstitutional for these same reasons.

A. The Act, Even If Narrowed, Does Not Survive the Scrutiny Applicable to Abortion Restrictions that Intrude on Bodily Integrity.

A law that prevents a woman from obtaining the safe pre-viability abortion procedure of her choice infringes upon her right to privacy. In *Casey*, this Court held that a woman's constitutional right to terminate her pregnancy incorporates

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[35] In addition, the suggested revision of the Act is too vague to pass constitutional muster, for it does not define with adequate precision what the State means by a "D&X" abortion. *See infra* at n.50.

[36] It therefore serves only the invidious purpose of banning and chilling the performance of abortions. *See infra* at **42-46**.

two strands of the right to privacy: the right to decisional autonomy and the right to bodily integrity. *Casey*, 505 U.S. at 849, 857. *See also City of Akron v. Akron Ctr. for Reproductive Health*, 462 U.S. 416, 427 (1983) (physician must be given room to exercise judgment in "both assisting the woman in the decisionmaking process and implementing her decision should she choose abortion"); *Benten v. Kessler*, 505 U.S. 1084, 1085 (1992) (Stevens, J., dissenting) (a woman's "constitutionally protected interest in liberty has two components -- her decision to terminate the pregnancy and her decision concerning the method of doing so.").

Prior to *Casey*, this Court employed strict scrutiny in assessing restrictions on the right to privacy, requiring that such restrictions be narrowly tailored to serve a compelling state interest in order to survive constitutional review. *See, e.g., Akron*, 462 U.S. at 427. Further, the two recognized state interests became compelling at different points in pregnancy: potential life after viability and maternal health after the first trimester. *Roe*, 410 U.S. at 163-64.

Casey expanded the States' authority to regulate abortion by permitting them to enact certain measures that promote the interest in potential life prior to viability.[37] 505 U.S. at 871-73. Specifically, States are permitted to dissuade women from having pre-viability abortions by measures calculated to "inform the woman's free choice, not hinder it," *id.* at 877, so long as these measures do not have the purpose or effect of imposing a substantial obstacle. *Id.* at 877-78. Thus, the *Casey* joint opinion adopted a mid-level "undue burden" standard for assessing restrictions on the woman's *decision* whether or not to carry her pregnancy to term. *Casey* did not, however, alter the constitutional standard of review applicable to statutes that restrict the *means* by which a woman terminates her pregnancy before viability. Such

[37] *Casey*, however, explicitly re-affirmed *Roe*'s standard of review for restrictions on post-viability abortions. 505 U.S. at 879.

statutes affect the woman's bodily integrity and health, but do not implicate the state's interest in potential life. Because no restrictions implicating bodily integrity were before this Court in *Casey*, that aspect of the privacy right continues to be subject to the same stringent protection it was given before *Casey*.[38]

This Court has twice held that statutes prohibiting a woman from using the abortion method of her choice violate her right to privacy. In *Thornburgh v. ACOG*, 476 U.S. 747 (1986), the Court struck down a statute that required women having life- or health-saving post-viability abortions to use the method most likely to result in a live birth unless doing so would "present a significantly greater medical risk to the . . . woman." *Id.* at 768. Because the statute "required a 'trade-off' between the woman's health and fetal survival and failed to require that maternal health be the physician's paramount consideration," *id.* at 768-69, it was unconstitutional. *See id.* at 769. *See also Jane L. v. Bangerter*, 61 F.3d 1493, 1502-05 (10th Cir. 1995) (striking post-viability "choice of method" statute), *rev'd on other grounds sub nom. Leavitt v. Jane L.*, 518 U.S. 137 (1996).

Similarly, in *Danforth*, this Court invalidated a ban on saline abortions, a type of induction procedure, which at that time was the most common method of second-trimester abortion. After closely examining whether the statute actually furthered the state's compelling interest in maternal health in the least restrictive manner, the Court concluded that Missouri's saline ban did not promote maternal health, but instead interfered with women's access to safe abortion procedures. *See id.* 428 U.S. at 76-79. It explained, "[t]he State . . . would prohibit the use of a method which the record shows is one of the most commonly used nationally by

[38] If the *Casey* "undue burden" standard does apply to restrictions on choice of abortion method, however, the Act is still invalid both as written and if narrowed to ban only D&X. *See infra* at 35-48.

physicians after the first trimester and which is safer, with respect to maternal mortality, than even continuation of the pregnancy until normal childbirth." *Id.* at 78. Although the Court appropriately recognized that, prior to viability, the state has a compelling interest in preventing the performance of *unsafe* procedures, it found that the state did not further that interest by forcing physicians to use techniques that are many times more likely to result in maternal death. *See id.* at 76, 78-79. Moreover, *Danforth* struck the ban even though methods of abortion *safer* than saline existed. *Id.* at 76-78.

The Act, like the provisions invalidated in *Danforth* and *Thornburgh*, implicates the bodily integrity strand of the right to privacy. The Act does not advance the state's legitimate interest in potential life by seeking to dissuade women from choosing abortion. Rather, it dictates the woman's (and her physician's) options once she has made the decision to end her pregnancy. Therefore, the determinative inquiry is not whether the State has unduly burdened women from making the "ultimate decision" of whether to have an abortion, *Casey*, 505 U.S. at 877, but rather whether the ban serves the state's interest in maternal health. *Danforth*, 428 U.S. at 76.

Far from promoting maternal health, the Act actually harms maternal health without justification. Even under the State's proposed revision, the Act prohibits a subset of D&E procedures, which are, as used by Dr. Carhart, not only safe and within accepted medical practice, but, as the district court found, the safest available procedures for some women. S.A. 62-63, 70-71; J.A. 61, 69, 101, 121-22, 125 (Carhart). In contrast, the Act's failure to "prohibit techniques that are many times more likely to result in maternal death," such as hysterotomy and hysterectomy, demonstrates that it does not serve the state's interest in maternal health. *Danforth*, 428 U.S. at 78.

Further, the Act impermissibly forces women to submit to additional and unnecessary medical procedures -- such as inducing fetal demise in utero, or unnecessary insertion of sharp instruments into the uterus -- as the price for seeking an abortion. S.A. 63; J.A. 69, 121-22 (Carhart), 268, 275-79 (Stubblefield). These medical procedures involve a substantial intrusion upon a woman's bodily integrity, far more than this Court has permitted in contexts where the state's reasons for infringing upon bodily integrity were more apparent. *See Winston v. Lee*, 470 U.S. 753, 766 (1985) (rejecting surgical operation to remove bullet for use as evidence in criminal prosecution); *Rochin v. California*, 342 U.S. 165, 172-73 (1952) (rejecting forcible stomach pumping to obtain evidence of crime). The State cannot force a woman seeking an abortion to undergo these intrusions on her bodily integrity, for it is simply intolerable to require a woman "to forfeit one constitutionally protected right as the price for exercising another." *Lefkowitz v. Cunningham*, 431 U.S. 801, 807-08 (1977); *Simmons v. United States*, 390 U.S. 377, 394 (1968).

On its face, the Act prevents a woman from choosing, in consultation with her physician, her preferred method of terminating a non-viable pregnancy. Not only will preventing a woman from obtaining a D&X abortion once she has decided to terminate her pregnancy flatly violate her right to make the "decision concerning the method of abortion," *Benten*, 505 U.S. at 1085 (Stevens, J., dissenting), it denies her physician the discretion to use his or her best medical judgment "in determining how [the] abortion [i]s to be carried out." *Colautti v. Franklin*, 439 U.S. 379, 387 (1979).[39] *See also Cruzan v. Director, Missouri Dep't of*

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[39] The role of the physician in making medical judgments related to the abortion has been recognized by this Court in two contexts: determining how to carry out the woman's decision to end her pregnancy, and assessing whether the fetus is viable. Even in the latter context, where the State's "profound" interest in potential life is most strongly present,

Health, 497 U.S. 261, 289 (1990) (O'Connor, J., concurring) ("Requiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment.").

Lastly, the Act harms maternal health by preventing the development of safer methods of abortion. A ban on a new abortion method or variation on an existing method ties the hands of physicians and risks halting the evolution of methods which has made abortion increasingly safe since 1973. *See supra* at 7-8. This Court has recognized the risk that proscribing methods of abortion poses to women. In *Danforth*, this Court struck down Missouri's ban on the use of "saline or other fluids" in part because this open-ended language would prohibit the use of "other methods that may be developed in the future and that may prove to be highly effective and completely safe." *Danforth*, 428 U.S. at 78. Indeed, this Court was prescient in that other methods were so developed. Likewise, the Act chills physicians' ability to develop newer, safer abortion methods. *See* Brief of ACOG, et al.

Because the Act intrudes on women's bodily integrity and the State cannot meet its burden of establishing that the Act serves the state's interest in maternal health, the Act is invalid on its face. *See Akron*, 462 U.S. at 438 & n.27 (striking second-trimester hospitalization requirement for abortions even though the statute had constitutional applications).

Casey, 505 U.S. at 877, this Court has carefully guarded the role of the physician's judgment. Accordingly, this Court and the lower federal courts have consistently refused to allow legislative judgments about viability to supplant the physician's judgment. *Colautti*, 439 U.S. at 388; *Danforth*, 428 U.S. at 64; *Hodgson v. Lawson*, 542 F.2d 1350, 1354 (8th Cir. 1976). The role of the physician in determining, in consultation with the woman, how to carry out a pre-viability abortion is worthy of at least as much protection.

B. The Act, Even if Narrowed, Imposes an Undue Burden on Women's Right to Seek Pre-Viability Abortions.

The courts below reviewed the Act under the undue burden test of *Casey*. The Act is invalid under this test as well, for two reasons. First, the Act infringes upon a woman's liberty without serving either of the state's legitimate interests, and is therefore a *per se* undue burden. This is particularly true because the Act actually disserves the state's interest in maternal health. Second, the Act's only purpose is the illegitimate one of enhancing legal protection for the fetus at the expense of women's health and liberty.

1. The Act's Effect is to Harm Women's Health Without Serving Any Legitimate Interest.

The Act, as most recently construed by the State, would prohibit Dr. Carhart from performing pre-viability abortions using the D&X procedure. Such a prohibition would force each woman who would otherwise obtain an abortion by a banned method to undergo a riskier form of D&E. *See supra* at 11. Unnecessary increased medical risks impose an undue burden on the woman's right to privacy. *See Hope*, 195 F.3d at 878 (Posner, C.J., dissenting) ("as banning 'partial birth' abortions is not intended to improve the health of women (or anyone, for that matter), it cannot be defended as a health regulation").

This Court has never approved even a *marginal* increase in risk to women's health or a limitation on the woman's choice of method unless such an increase was offset by a demonstrable corresponding benefit.[40] Thus, while

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[40] The State, like the Seventh Circuit in *Hope*, also wrongly inverts the burden of proof in abortion cases. Nebraska must prove that a regulation *furthers* its interest in maternal health; it is not a physician's burden to show that a regulation harms women's health, although this has been shown here. Under "intermediate scrutiny" standards, such as the undue

recognizing that Pennsylvania's mandatory 24-hour delay would marginally increase the risks associated with an abortion, 505 U.S. at 886, *Casey* approved that increased risk because it also benefited women's health by making their decisions more informed. *Id.* at 885. Likewise, although parental involvement laws undoubtedly delay minors in obtaining abortions (thus increasing the medical risks of the procedure), because they help ensure that the minor's decision is well-informed, the increased risk is tolerable. In contrast, the Act imposes an increased risk on women and restricts the exercise of their rights without conferring any corresponding benefit -- its only effect is to render abortions more dangerous and infringe on women's right to privacy. Thus, the Act imposes a *per se* undue burden. *See Planned Parenthood v. Doyle*, 162 F.3d 463, 468-69 (7th Cir. 1998).

Purportedly relying on *Casey*, the State argues that, because banning D&X does not cause a *significant* threat to a woman seeking an abortion, and other safe procedures remain available, it is permissible. Pet. Br. at 34-35. This argument is legally wrong and rests on an erroneous factual assumption.

First, the State is barred from imposing even marginal risks on women's health unless those risks are justified by serving a legitimate interest.[41] As *Casey* holds, "a statute which, *while furthering the interest in potential life or some*

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burden standard, the State must do more than baldly assert that legitimate interests are served. *See, e.g., United States v. Virginia*, 518 U.S. 515, 532 (1996) ("the burden of justification is demanding and it rests entirely on the State. . . . The justification must be genuine, not hypothesized or invented post hoc in response to litigation."). *See also Turner Broadcasting System, Inc. v. FCC*, 512 U.S. 622, 624 (1994) (applying intermediate scrutiny and requiring that asserted harms be "real, not merely conjectural").

[41] Thus, the absence of studies proving D&X is safer than other abortion methods proves nothing; to ban D&X, the State must affirmatively demonstrate that banning D&X promotes women's health.

other valid state interest, has the effect of placing a substantial obstacle in the path of the woman's choice cannot be considered a permissible means of serving its legitimate ends." *Casey*, 505 U.S. at 877 (emphasis added). Here, there is no evidence that the Act furthers *any* valid state interest. *Casey* upheld a 24-hour waiting period because it furthered the state interests in dissuading some women from having an abortion and rendering their decision more informed. *See id.* at 882-83. Moreover, the Court also found that in the "vast majority of cases, a 24-hour delay does not create any *appreciable* health risk," *id.* at 885 (emphasis added);[42] and the delay was waived if it would, in a particular case, "in any way pose a significant threat to the life or health of a woman." *Id.* at 880. Thus, *Casey* upheld the Pennsylvania law because it served the state's interest in discouraging abortion at the price of a marginal health risk to women; where the health risk rose to the level of a "significant threat," the statute was inapplicable. *Casey* did not address threats to women's health or bodily integrity that serve no legitimate state interest whatsoever.

In contrast to the statute upheld in *Casey*, the Act serves no state interest in dissuading abortion; thus, the health risks and intrusions on bodily integrity it imposes on women are utterly gratuitous. Banning a particular procedure before viability when others remain available serves no interest in potential life and does not inform women's decisions. *See Doyle*, 162 F.3d at 470. Nor does a statute which imposes increased risks on the woman seeking an abortion serve any state interest in maternal health. *Cf. Jane L.*, 61 F.3d at 1502-06.

The remaining purported state interests suggested by the State are either not legitimate under *Casey*, or are not served

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[42] In contrast, the record here shows that forcing a woman who would otherwise obtain a D&X abortion from Dr. Carhart to obtain another form of abortion *would* pose appreciable health risks. *See supra* at 11.

by the Act. The State contends that the Act serves its interests in: (1) showing concern for the life of the unborn, "and more specifically for the partially-born"; (2) "preventing cruelty to partially-born children and unacceptable disrespect for potential human life"; and (3) "preserving the integrity of the medical profession." Pet. Br. at 48 (internal quotations omitted). The first two interests are simply "moral" stances that the State cannot enforce at the expense of women's constitutional rights. This Court has recognized that the decision to terminate or continue a pregnancy is one about which "men and women of good conscience can disagree." *Casey*, 505 U.S. at 850. Because the intensely personal decision implicates a protected liberty, this Court has explicitly held that the states "may not compel or enforce one view or the other." *Id.* at 851. Thus, this Court has rejected the suggestion that moral disapproval of abortion is a legitimate basis for restricting the procedure. *See also Hope*, 195 F.3d at 881 (Posner, C.J., dissenting) ("if a statute burdens constitutional rights and all that can be said on its behalf is that it is the vehicle that legislators have chosen for expressing their hostility to those rights, the burden is undue"). Further, if moral stances such as those asserted by the State could serve as legitimate bases for an abortion restriction, they would justify complete abortion bans, in violation of *Roe* and its progeny.[43] Indeed, the State suggests that these two interests support a ban on a broader range of abortions. *See* Pet. Br. at 49 n.31. Finally, the State's last asserted interest in the integrity of the medical profession is undermined, not served, by the Act's usurpation of the physician's medical judgment, its criminalization of

[43] The Seventh Circuit's upholding of abortion restrictions that served only "moral . . . considerations" therefore clearly violates this Court's abortion jurisprudence. *See Hope*, 195 F.3d at 875.

safe, medically accepted surgical techniques, and its thwarting of future medical progress.[44]

Since the Act fails to "further[] the interest in potential life or some other valid state interest," and thus gratuitously threatens women's health and bodily integrity, it is unconstitutional under *Casey*. *Id.*, 505 U.S. at 878 (regulations "designed to persuade [the woman] to choose childbirth over abortion . . . [or] to foster the health of a woman seeking an abortion are valid if they do not constitute an undue burden"). *See Hodgson v. Minnesota*, 497 U.S. 417, 436 (1990) (citations omitted) (opinion of Stevens, J., joined by Brennan, J.) ("Under any analysis, the [parental notice for abortion] statute cannot be sustained if the obstacles it imposes are not reasonably related to legitimate state interests."); *id.* at 459 (O'Connor, J., concurring in part and concurring in the judgment in part) (same); *Danforth*, 428 U.S. at 71 (spousal consent for abortion, even if constitutionally permissible, was unlikely to further the state's asserted interest).

Even accepting *arguendo*, and in spite of the contradictory case law, the State's position that the Act is constitutional so long as it does not cause a significant threat to a woman seeking an abortion, the State's argument still fails. The district court here correctly found that banning the D&X procedure would subject Dr. Carhart's patients who currently undergo D&X procedures to appreciably greater *and* unnecessary risks to life and health. S.A. 64. Accordingly, the Act is unconstitutional even under the State's proposed standard.

[44] The State cites, in support of its claim that this interest is served, a passage of testimony from Dr. Boehm, J.A. 640, describing his concededly personal beliefs, *see* J.A. 672-75, about what types of abortion are "moral." Dr. Boehm's views simply express, in different language, the same "moral" interests that the State terms concern and respect for the unborn.

The State attacks at great length the district court's conclusion that a ban on the D&X procedure would place a substantial risk on a number of Respondent's patients. The State argues that the district court's findings of fact should be ignored as "incredible."[45] Pet. Br. at 38. Of course, a district court's factual findings facts must be upheld unless clearly erroneous. Fed. R. Civ. P. 52(a); *Concrete Pipe and Prods. of California v. Construction Laborers Pension Trust for Southern California*, 508 U.S. 602, 622-23 (1993); *Salve Regina College v. Russell*, 499 U.S. 225, 233 (1991). Here, the district court found that Dr. Carhart's use of the D&X procedure is "appreciably safer than the D&E procedure," S.A. 62, for several reasons, *see supra* at 11, each of which finds ample support in the record. S.A. 62-64. Those factual findings accord with other district courts' findings that D&X is the safest abortion method for some women. *See Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1068-71 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert denied*, 523 U.S. 1036 (1998); *A Choice for Women*, 54 F. Supp. 2d at 1152-54; *see also Doyle*, 162 F.3d at 468 ("the balance of evidence on the issue of health [is] decisively inclined in favor of the plaintiffs"); *Verniero*, 41 F. Supp. 2d at 484-85.

The State asserts that the evidence does not show that the D&X procedure is safer, only that it has the potential to be safer. *See* Pet. Br. at 44-45. The district court, however, properly relied on expert testimony regarding the reasons that the D&X procedure may be safer and on the testimony from Dr. Carhart describing his use of the procedure, which confirmed that the D&X procedure is, in fact, safer for some women. *Id.*

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[45] The State also claimed that "only a handful of physicians in the entire country use the procedure even occasionally." Pet. Br. at 38. However, there is no evidence in the record supporting this claim, nor is there any evidence in the record about the prevalence of D&X in the United States.

The State also attacks the district court's factual conclusions by arguing that: there are no medical studies or articles demonstrating the safety of the D&X procedure; it is incorrect to base any conclusions about the safety of D&X on knowledge gained by doing D&Es; and D&X is not taught in medical schools. Pet. Br. at 38-39, 41 n.27. These arguments demonstrate only that the D&X variant is new, not that it is unsafe. A surgical procedure can obviously be new but not unsafe. J.A. 311-12 (Stubblefield), 675-76 (Boehm). Moreover, this criticism of the district court's findings improperly seeks to shift the burden of proof in abortion litigation. Under this Court's precedents, the State has the burden of proof in establishing that the Act actually promotes women's health; it may not satisfy this burden by asserting that there is no evidence that it won't. *See supra* at n.40.

The State also attacks the district court's decision to credit the testimony of Respondent's witnesses and discredit portions of the testimony of the State's expert witnesses. The credibility of witnesses is a question uniquely within the province of the district court, Fed. R. Civ. P. 52(a); *Hernandez v. New York*, 500 U.S. 352, 364 (1991); *Anderson v. City of Bessemer City, N.C.*, 470 U.S. 564, 575 (1985), and the State has given no persuasive reason to disturb the district court's credibility findings.[46]

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[46] First, the district court credited the testimony of Respondent's expert witnesses, both abortion providers, because of their extensive experience in performing abortions. The district court properly discredited the testimony of one of the State's experts, Dr. Riegel, because he does not perform any abortion procedures whatsoever. S.A. 45. *See Planned Parenthood v. Ashcroft*, 655 F.2d 848, 857 n.12 (8th Cir. 1981), *rev'd in part on other grounds*, 462 U.S. 476 (1983).

The district court also properly *discredited* Dr. Frank Boehm's testimony that D&X is not safer than other procedures. S.A. 41-42, 62-63. Dr. Boehm based his opinion on the lack of any studies on the topic, *see* S.A. 41, yet later undermined his position by testifying that he and other physicians considered newly developed abortion procedures safe and integrated them into their practices prior to any studies on their safety.

Lastly, the State argues that the district court should have deferred to the Nebraska Legislature's determination of the safety of the D&X procedure. But this Court does not defer to legislative determinations that affect the exercise of constitutional rights, for to do so would eliminate all judicial protection for these rights. *See, e.g., Danforth*, 428 U.S. at 76-79 (assessing safety of saline amniocentesis); *Akron*, 462 U.S. at 437 (assessing safety of D&E outpatient procedure). Indeed, this is precisely the error made by the Seventh Circuit in *Hope*, which reviewed similar legislation under what amounts to less than even rational basis review. *Hope*, 195 F.3d at 874-75.

2. The Act's Purpose is Illegitimate.

The Nebraska Legislature enacted the Act with the impermissible purpose of narrowing the right to abortion recognized by this Court in *Roe* and *Casey*. This unconstitutional purpose is demonstrated by: (1) the posture taken by the State in defense of the Act; (2) the abortion restrictions already in place in Nebraska; (3) the statements of the Act's sponsors; and (4) the lack of even a rational relationship between the Act and the State's legitimate purposes. Each of those factors supports the conclusion that

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S.A. 43; J.A. 669, 675-76. Dr. Boehm's opinion was also undermined by: Dr. Stubblefield's testimony, which the district court found "particularly persuasive," S.A. 45; Dr. Boehm's ability to assess without any studies the safety of variations on the D&E procedure (J.A. 652-53); Dr. Boehm's relative inexperience with the D&E procedure (J.A. 627, 654-55, 692, 709); Dr. Boehm's admission that he is not in touch with current D&E procedures (J.A. 654-55); and the testimony of Dr. Carhart, who has successfully performed the procedure.

The State also argues that Respondent's witnesses were biased because of their views on abortion and because of their ties to the case. Pet. Br. at 37-38, 40-41. Conversely, the State argues that one of its witnesses, Dr. Boehm, had no reason to be biased. The district court was aware of these sources of potential bias or the lack thereof. Nothing in the record indicates that the district court did not properly take these factors into consideration in assessing the credibility of the witnesses.

"the Legislature's predominant motive . . . was to create a 'substantial obstacle' to abortion." *Mazurek v. Armstrong*, 520 U.S. 968, 974 n.2 (1997) (internal quotations omitted).

First, the State's improper purpose is demonstrated by the position the State has taken in defense of the Act. *See Jane L. v. Bangerter*, 102 F.3d 1112, 1117 (10th Cir. 1996) (state's improper purpose was "confirmed by the State's briefs on appeal, in which the State in essence concedes that the section was intended to prevent [certain abortions]. . ."). *See also Shaw v. Hunt*, 517 U.S. 899, 906 (1996) (state's concessions regarding purpose were properly relied upon by district court in finding improper purpose). Most tellingly, in petitioning for certiorari, the State asked this Court not simply to uphold the Act, but to use consideration of the Act as an opportunity to overturn all of the Court's prior abortion jurisprudence and hold that abortion is not constitutionally protected. Pet. for Cert. at 16-18. This is clear evidence that the Act's purpose was not to serve a legitimate state interest, but "to provide a vehicle by which to challenge *Roe v. Wade*." *Jane L.*, 102 F.3d at 1116.

The State has not argued that the Act can be reconciled with this Court's abortion jurisprudence, which permits only insubstantial burdens on the abortion decision prior to viability, and then only when those burdens legitimately further the interests in maternal health or potential life. *Casey*, 505 U.S. at 876-77. Instead, the State attempts to discard that entire framework and replace it with one in which a fetus is accorded legal protection, regardless of viability, once a physician begins removing the fetus from the woman's uterus. *See, e.g.*, Pets.' Br. at 10-11, 29-30, 33-34. The State's repeated attempts to curtail the protections of *Roe* and *Casey* in the course of defending the Act demonstrate its true and impermissible purpose -- to place a substantial obstacle in the path of women seeking abortions.

Second, the Act's purpose is demonstrated by Nebraska's pre-existing statutory framework. *See Michael M. v. Superior Ct. of Sonoma Cty.*, 450 U.S. 464, 469-71 & n.6 (1981) (examining statutory framework for evidence of law's intent). Prior to passage of the Act, Nebraska already limited the performance of abortions to physicians licensed in the State. Neb. Rev. Stat. § 28-335 (enacted 1977). Nebraska's scheme for physician licensing includes means of investigating physicians and revoking physician licenses for such offenses as unprofessional conduct or a pattern of negligent conduct. Neb. Rev. Stat. §§ 71-168(1); 71-147(10); 71-148. Moreover, physicians licensed by the State of Nebraska are "recognized by the State as capable of exercising acceptable clinical judgment." *Doe v. Bolton*, 410 U.S. at 199. Thus, prior to passage of the Act, Nebraska already had legal mechanisms for ensuring that abortions are performed by doctors capable of deciding which procedures are medically appropriate for their patients. In addition, Nebraska already prohibited post-viability abortions except to save the life or health of the woman, and required that any post-viability abortions legally performed utilize the abortion method most likely to preserve the life of the fetus. Neb. Rev. Stat. §§ 28-329, 28-330. Finally, prior to passage of the Act, Nebraska already required that women seeking abortions receive a range of information about their pregnancies, the nature and risks of abortion procedures, and alternatives to abortion at least twenty-four hours prior to consenting to an abortion procedure. Neb. Rev. Stat. §§ 28-327, 327.01 (1995 & Supp. 1996). Accordingly, the State had already implemented measures to inform the woman's decision and dissuade her from undergoing an abortion. In light of this statutory scheme, the Act is either entirely superfluous or aims to criminalize abortions that are constitutionally protected under this Court's abortion jurisprudence. *See Hope Clinic v. Ryan*, 995 F. Supp. 847, 860 (N.D. Ill. 1998) (statute was either superfluous or intended to ban safe, pre-viability abortion procedures),

rev'd, 195 F.3d 857 (7th Cir. 1999); *see also Alaska*, slip op. at 11 ("Having passed the Act with knowledge of the legal defects, it seems more likely than not that the unstated purpose of the Act was to cloud the scope of abortion procedures, i.e., to restrict abortion in general.").

Additionally, the explicit statements of the Act's sponsors demonstrate that the purpose of the Act was to chill the performance of safe, commonly used abortion methods without regard to fetal viability. *See Edwards v. Aguillard*, 482 U.S. 578, 587 (1987) (relying on statements made by law's sponsor to determine law's purpose). As described above, the bill's primary sponsor, Senator Maurstad, knew that the Act bans more procedures than just D&X. More specifically, he recognized that the Act encompasses abortions even where: (1) the procedure is performed during the first trimester of pregnancy; (2) the fetus is removed in a head-first position; (3) fetal demise is caused by dismemberment rather than compressing the cranium; and (4) fetal demise is caused after virtually any part of the fetus has been brought into the vagina. *See supra* at 4-6. Nonetheless, Senator Maurstad instructed other legislators that the Act should not be changed to include a definition that would have limited the Act's reach to avoid these consequences. *See supra* at 5. These statements show that the intent of the Act's sponsors was to ban, or at least chill, the performance of a range of common abortion methods without regard to fetal viability.

Finally, the Court may infer an impermissible purpose because, as already described, *see supra* at 35-42, the Act is not even rationally related to advancing either of the legitimate state interests that may justify restrictions on abortion: maternal health or potential life. *See Washington v. Davis*, 426 U.S. 229, 241-42 (1976) (examining the impact of official action to ascertain its purpose). The failure of the

Act to serve either of the recognized, legitimate state interests which may undergird abortion restrictions is powerful evidence that its actual purpose is the impermissible one of thwarting access to safe abortions. *See Hope*, 195 F.3d at 882 (Posner, C.J., dissenting) ("Here the intent is to block a woman from seeking an abortion when her doctor advises her that the best procedure for her is criminal."). As the Eighth Circuit held recently, "Where a requirement serves no purpose other than to make abortions more difficult, it strikes at the heart of a protected right, and is an unconstitutional burden on that right." *Planned Parenthood v. Atchison*, 126 F.3d 1042, 1049 (8th Cir. 1997) (citation omitted). Indeed, the Nebraska legislature's willingness to jeopardize, rather than protect, maternal health is simply further evidence that the Act is "an unreasonable or arbitrary regulation designed to inhibit . . . the vast majority of abortions." *Danforth*, 428 U.S. at 79.

C. Even if Narrowed, the Act is Unconstitutional Because it Lacks an Adequate Exception for Sick or Dying Women.

Abortion restrictions must contain adequate provisions to preserve a woman's life *and* health, even post-viability. *Casey*, 505 U.S. at 879-80; *Thornburgh*, 476 U.S. at 768-69; *Jane L.*, 61 F.3d at 1503-04. An adequate life and health provision must cover not only situations where the woman is facing physical harm but also "situations where a woman is faced with the risk of severe psychological or emotional injury which may be irreversible." *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 210 (6th Cir. 1997), *cert. denied*, 523 U.S. 1036 (1998). *See also Casey*, 505 U.S. at 882 ("It cannot be questioned that psychological well-being is a facet of health."); *Bolton*, 410 U.S. at 192.

The Act lacks adequate health and life exceptions and is thus invalid. For example, under the Act, the parents of a young teenager who is suicidal because she is pregnant as a

result of forcible rape cannot, in assisting her "to exercise [her] rights wisely," *Hodgson v. Minnesota*, 497 U.S. 417, 444 (1990) (opinion of Stevens, J., joined by O'Connor, J.), consent to a D&X abortion for her even if both they and her physician believe it is the safest method. And, under the Act, a woman who is sick, but not dying, from a pregnancy is compelled to use an abortion method that is not the safest for her. *See generally Jane L.*, 61 F.3d at 1502-05.

The State argues that requiring a health exception would prevent states from regulating abortion at all. This is simply incorrect.[47] States may regulate abortion but must always include adequate health and life exceptions. *Casey*, 505 U.S. at 879. This Court has never permitted a State to substitute its judgment for the physician's about when a woman's health is compromised.

Unsurprisingly, then, federal courts reviewing partial-birth abortion bans have found their lack of any health exception is an independent reason to find them unconstitutional. *See, e.g., Woods*, 982 F. Supp. at 1378; *Verniero*, 41 F. Supp. 2d at 501-503; *Butterworth*, 54 F. Supp. 2d at 1156-57. The one court that has departed from this principle misapprehends *Casey*'s requirement that any abortion regulation must give the physician room to protect the health of *each* of his or her patients. *See Hope*, 195 F.3d at 873.

The Act's cramped "life" exception also renders the Act unconstitutional, because it does not permit a partial-birth

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[47] For example, this Court has permitted the States: to require parental consent or notice for minors seeking abortions so long as an adequate judicial bypass mechanism is also provided, *see Casey*, 505 U.S. at 899; to limit the performance of second-trimester abortions to ambulatory surgical centers, *see Simopoulos v. Virginia*, 462 U.S. 506 (1983); and to require that adult women be given state-scripted information designed to dissuade them from having an abortion, and that women be required to wait 24 hours to deliberate on that information. *See Casey*, 505 U.S. at 881-87.

abortion when a pregnant woman's life is threatened by mental illness.[48] *See Voinovich*, 130 F.3d at 209. By enumerating certain life-threatening conditions -- a physical disorder, physical illness, or physical injury -- the legislature must have intended to exclude others, such as mental illness. *See, e.g., Nebraska City Educ. Ass'n v. School Dist. of Nebraska City*, 267 N.W.2d 530, 532 (Neb. 1978). The exclusion of mental illness is impermissible. *See supra* at 46.

Perhaps recognizing these shortcomings, the State argues that life and health exceptions are not necessary because the Act regulates only the *method* of abortion. Pet. Br. at 30. But this Court rejected precisely this argument in *Thornburgh*. 476 U.S. at 768. The State's position is untenable because the Constitution protects the bodily integrity of a woman seeking an abortion and does not require a woman to risk her health and life at the state's whim or even to benefit the fetus. *See supra* at 29-34. Accordingly, the Act's lack of a health exception and an adequate life exception renders it unconstitutional. The judgment of the court of appeals should be affirmed on this ground as well.

III. THE ACT IS VOID FOR VAGUENESS.

The Act is impermissibly vague, chiefly because its constituent term "substantial portion" has no core meaning

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[48] Even when the Act's limited exception applies, a physician's good-faith determination that the procedure is necessary to save the woman's life from a life-endangering physical condition, illness, or injury does not preclude a jury from later second-guessing that conclusion. This will chill physicians from providing life-saving care for fear of the Act's daunting criminal penalties and thus also renders the Act's exception constitutionally defective. *See Verniero*, 41 F. Supp. 2d at 503 (finding unconstitutional similar exception in part because it "does not protect the physician's ability to make a judgment call as required by *Roe*").

and therefore leaves physicians to guess at what conduct the Act actually prohibits.[49]

Criminal statutes must give adequate notice of the conduct they prohibit. *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). A law must give the persons targeted by the law "a reasonable opportunity to know what is prohibited so that [they] may act accordingly." *Grayned*, 408 U.S. at 108. Moreover, where a law threatens to inhibit the exercise of constitutional rights, as does the Act, greater scrutiny for possible vagueness is warranted. *Colautti v. Franklin*, 439 U.S. 379, 391 (1979). The Act fails these requirements.[50]

The district court held that the term "substantial portion" in the Act was void for vagueness. S.A. at 86-87. This conclusion is fully supported by the numerous and conflicting explanations of the term in the Act's legislative history, and it dooms the Act as a whole. Unless physicians are given clear guidance about how much of a fetus can legally be removed from the woman's uterus before triggering the Act, they will be unable to conform their conduct to the Act. Moreover, the numerous definitions of "substantial portion" that appear in the record are fodder for

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[49] The term "living" is also vague in the context of a pre-viability abortion. In every such abortion, fetal demise is inevitable, yet the fetus may continue to have a heartbeat, living tissue or living cells throughout the procedure. *See, e.g.*, J.A. 258, 260, 268 (Stubblefield); J.A. 151 (Hodgson). The Act does not give physicians notice of which criteria determine whether the fetus is "living." *See* S.A. 86 n.47.

[50] The State's proposed revision of the Act to limit it to certain abortions the State calls "D&X" is equally vague. *See Hynes v. Mayor and Council of Oradell*, 425 U.S. 610, 622 (1976) (limiting construction of ordinance by state supreme court itself found vague). It departs radically from the Act's text and leaves physicians to guess, at peril of lengthy imprisonment, exactly which abortions are prohibited. For example, the State's gloss requiring a "separate death-causing procedure" compounds the Act's vagueness. How is a physician to know which conduct constitutes a "separate procedure," as opposed to a step within a procedure? The State provides no guidance, and the Act is silent.

arbitrary and discriminatory enforcement of the Act. The inevitable effect of this vague term will be, therefore, to cause Dr. Carhart and other Nebraska physicians to "steer well clear of the forbidden zone." *Hope*, 195 F.3d at 889 (Posner, C.J., dissenting).

Based on this evidence, the district court properly held that "the words 'substantial portion' are so vague as to be meaningless to doctors, lay people and prosecutors alike," and that, therefore, the Act is "the epitome" of a vague statute. S.A. 87. This Court should affirm the decision below on this basis as well.

CONCLUSION

For all the foregoing reasons, and in order to guarantee that the women of Nebraska and the United States continue to have access to the safest abortions and are not subject to invidious efforts to interfere with their right to privacy, the judgment of the court of appeals should be affirmed.

March 29, 2000.

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In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

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ARGUMENT

I. A National Consensus Exists For Banning Partial-Birth/D&X Abortion and The Public Does Not Accept the D&X Procedure As Being Within The Scope of Constitutionally-Protected Conduct.

The Respondent opens his brief with the Orwellian declaration that "All available evidence refutes the State's assertion that the public supports the nationwide campaign to ban 'partial-birth abortions.' " Brief of Resp. at 1 n.1. On the contrary, large bi-partisan majorities consisting of both pro-choice and pro-life legislators have voted to ban the procedure in thirty States and both houses of Congress (as recently as April 6, 2000 in the U.S. House of Representatives). As this Court has stated, " '[T]he primary and most reliable indication of [a national] consensus is . . . the pattern of enacted laws.' " ***Washington v. Glucksberg,*** 521 U.S. 702, 711 (1997) (bracketed material in original) (quoting ***Stanford v. Kentucky,*** 492 U.S. 361, 373 (1989)).

Not only is there a national consensus among elected state and federal legislators, but the general public clearly does not view the partial-birth abortion procedure as falling within the liberty right protected by ***Roe v. Wade*** and ***Casey***. A Wirthlin poll found that 73% of Americans favored banning partial-birth abortion when they were presented a brief general description of the procedure. Wirthlin Worldwide Poll, Nov. 3, 1998. Even when the question posed did not provide a description of the procedure, 64% of Americans favored banning partial-birth abortion in a 2000 Gallop Poll. ***See*** www.gallup.com/poll/indicators/indabortion.asp (Jan. 13-16, 2000). ***See also*** Brief of Amicus Curiae Agudath Israel at 10.

Given the public's overwhelming revulsion with partial-birth abortion, a determination that partial-birth abortion is a constitutionally protected activity would clearly not be accepted as "a common mandate rooted in

the Constitution." ***See Planned Parenthood of Southeastern Pennsylvania v. Casey,*** 505 U.S. 833, 867 (1992).

II. Nebraska's Ban on Partial-Birth Abortion Serves Legitimate State Interests.

The Respondent relies heavily on the asserted proposition that the only legitimate interests which a State may assert in the context of abortion regulations are maternal health and preserving "potential" life by dissuading women from having an abortion. Brief of Resp. at 35-39. However, there are additional legitimate State interests here, including the State's compelling interest in erecting a barrier to infanticide and the State's interest in showing respect for the "potential" life of the living unborn child. *See* Brief of Pet. at 48-49.

The advent of doctors killing human infants who are mostly outside the womb and dangling just inches from complete birth is a fundamental change in circumstances, ***Casey,*** 505 U.S. at 863-864, which gives rise to State interests not heretofore discussed by the Court. ***See*** Brief of Pet. at 29-30 (discussing the changed "factual underpinnings" since ***Casey,*** and specifically the public's understanding of what constitutes an abortion). ***See also*** Brief of Amici Curiae Congressman Canady, et al. at 22-29 (discussing the States' interest in protecting partially-born children); Brief of Amicus Curiae Family Research Council at 5-18 (discussion of the States' interest in preventing infanticide); Brief of Amici Curiae States of Louisiana and Mississippi at 14-19; Brief of Amici Curiae Association of American Physicians and Surgeons, et al. at 27-28 (States' interest in preserving the integrity of the medical profession).

The Respondent claims that "Banning a particular procedure before viability when others remain available serves no interest in potential life. . . . " Brief of Resp. at 37. The Respondent's position, however, falsely assumes the Court is constitutionally bound to turn a deaf ear and

a blind eye to the nationwide gasp of horror at a procedure whereby near-viable living infants are literally pulled from the womb and, with legs kicking and fingers clasping, have their skull pierced and their brains suctioned from their head while poised at the very precipice of personhood. ***See*** Brief of Pet. at 3-4. As pro-choice Senator Daniel Patrick Moynihan stated, in explaining his vote to override a presidential veto of a congressional ban on partial-birth abortion, "the procedure was too close to infanticide. . . . And now we have testimony that it is not just too close to infanticide, it is infanticide, and one would be too many." Brief of Amici Curiae Congressman Canady, et al. at 17 (quoting Congressional Quarterly, March 15, 1997). A nation so callous or cavalier as to recognize "no legitimate interest" in stopping such a procedure cannot rightly be called civilized. Our Constitution was not drafted by such people, and the history of the Fourteenth Amendment does not support its use as a means of legitimizing such atrocity in the name of "liberty." ***See*** Brief of Resp. at 29-39.

III. The Absence of a Health Exception Does Not Create an Undue Burden in the Context of a Ban on the Partial-Birth Abortion/D&X Procedure.

A. The Respondent's Demand for Strict Scrutiny is Inconsistent With *Casey*.

In order to address the health exception aspect of this case, it must first be determined what standard of review applies. Eight years ago this Court held that state abortion regulations would be upheld "which in no real sense deprived the woman of the ultimate decision" to terminate a pregnancy prior to fetal viability. ***Casey,*** 505 U.S. at 875. The Court expressly abandoned the prior legal framework, which had not fulfilled ***Roe's*** promises regarding the interests of the States, and adopted the

undue burden test. *Id.* at 876. In disregard of this decision, the Respondent now asserts that any state legislation which restricts "the *means* by which a woman terminates her pregnancy before viability" continues to be subject to "strict scrutiny . . . requiring that such restrictions be narrowly tailored to serve a compelling State interest in order to survive constitutional review." Brief of Resp. at 30-31. The Respondent's proposed standard of review would overrule *Casey*, and would significantly undervalue the interests of the State.

B. The D&X Procedure is Never Necessary to Preserve the Health of Women.

The absence of a health exception in the statute does not create an undue burden since the D&X procedure is never necessary to preserve the health of women. The Respondent and amicus curiae ACOG are unable to articulate any concrete category of situations where the D&X procedure would be necessary to preserve the health of women. The only specific situations suggested where a D&X procedure may even be "the most appropriate abortion method" are 1) where the infant has hydrocephalus; 2) where "intactness [of the body] allows unhampered evaluation of structural abnormalities"; and 3) where "an intact fetus can aid . . . patients grieving a wanted pregnancy by providing the opportunity for a final act of bonding." Brief of Amicus Curiae ACOG at 23. First of all, the modern induction procedure would satisfy any need to have an intact child and would also be superior for bonding. More importantly, though, facilitating parental bonding with a dead child and facilitating autopsies are not interests which outweigh the State's compelling interests in the child. Thus, the only facially plausible situation proposed by the Respondent in which the D&X procedure could be necessary in order to preserve a woman's health is when the child has hydrocephalus.

However, the record is clear on this question, and it contradicts the Respondent's claim.

The State presented testimony by one of the country's leading experts on this question, Dr. Frank Boehm. J.A. 561-598. Dr. Boehm's practice includes second trimester abortions, including abortions involving congenital anomaly where there are "serious malformations of the fetus." J.A. 621; Brief of Pet. 40. Dr. Boehm testified that in situations where an unborn child has hydrocephalus he drains away the fluid from the child's head using a procedure called cephalocentesis, and does not need to remove brain tissue. J.A. 700-703 ("if we needed to, we would decompress the head with the cephalocentesis procedure. . . . But our intent is not to cause death with that procedure."). ***See also*** Brief of Amici Curiae Association of American Physicians and Surgeons, et al. at 25-26 (discussion of hydrocephalus and diagnosis of fetal abnormalities); Brief of Amicus Curiae State of Wisconsin at 26-28; Brief of Pet. at 37-38.

Contrary to the assertion of the Respondent, the effect of Nebraska's statute is not to "harm women's health." The physician who developed the D&X procedure, Dr. Martin Haskell, has testified that "the D&X procedure is never medically necessary to . . . preserve the health of a woman." ***Planned Parenthood of Wisconsin v. Doyle,*** 44 F. Supp.2d 975, 980 (W.D. Wis. 1999), *vacated on other grounds,* 195 F.3d 857 (7th Cir. 1999). Likewise, the author of the most widely used textbook on abortion standards and procedures, Dr. Warren Hern, testified to Congress that "he could not imagine a circumstance in which this [D&X] procedure would be safest." Congressional legislative history of the Partial-Birth Abortion Ban Act of 1995, H.R. 1833, 105th Cong. (1995) at 356.

The Respondent's own expert witness, Dr. Stubblefield, acknowledged that it is not "medically-accepted" that D&X is a safer abortion procedure. J.A.

310-311. In fact, no one has ever done any research comparing the safety of D&X to other procedures. J.A. 704. ***See also*** Brief of Amicus Curiae State of Wisconsin at 19-25 (discussing testimony on the safety of D&X vs. D&E). Significantly, official state abortion reporting data shows that in States where bans on partial-birth abortion have been in effect, physicians have not modified their abortion procedures to the detriment of their pregnant women patients. Brief of Amicus Curiae Family First at 21 (summarizing abortion data from states where bans on partial-birth abortion have been in effect).

Interestingly, Dr. Carhart testified that for any abortion over 15 weeks gestation he "intends and prefers to remove the fetus intact by using the intact D&E [D&X] procedure. . . . " Supp.App. at 15. However, he simultaneously maintains that he "does not perform instrumental conversion of the fetus to a footling breech. . . . " Supp.App. at 16. Thus, the Respondent avoided review by the trial court of one of the most controversial aspects of the typical D&X procedure as described by the American College of Obstetricians and Gynecologists (instrumental conversion of the unborn child to a breech or foot-first position). Supp.App. at 15. ACOG implicitly acknowledges that "internal podalic version, in which the physician repositions the fetus into a footling breech. . . . ", Brief of ACOG at 23, is a health risk. ***Id.*** at 24 n.34 ("it is perfectly consistent for Dr. Carhart to conclude . . . that the potential safety advantages of D&X are reduced (and even outweighed) when he must convert the fetus from a transverse or compound presentation.").

Perhaps this explains why even after completion of the trial and submission of all evidence in this case, the Respondent's litigation position with regard to the relative safety of the D&X procedure was only that it was

"likely to be as safe as other abortion methods. . . . "[1] The assertions of the Respondent as to the alleged safety of the D&X procedure became significantly more bold after release of the trial court's opinion. In other words, the Respondent has bootstrapped his safety assertions for the D&X procedure using the district court's findings – findings which went far beyond what the Respondent asked for at trial. ***Id.*** Notwithstanding the overreaching conclusions of the district court, the record shows that safe alternative procedures are available, and a ban on partial-birth/D&X abortion would create no risk to the health of women. ***See*** Brief of Pet. at 40-44.

C. The Respondent's Proposed Standard for Health Exceptions is Inconsistent With the Undue Burden Test as it Would Effectively Institute Abortion on Demand.

After broadly construing Nebraska's statute as a ban on virtually all abortion procedures, the Respondent then relies on this Court's decision in ***Planned Parenthood of Central Missouri v. Danforth,*** 428 U.S. 52 (1976), to argue for its unconstitutionality. Brief of Resp. at 24. However, since Nebraska's statute may reasonably be construed as banning only the D&X procedure, ***See*** section IV, ***infra*** at

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[1] The Respondent argued to the district court in his post-trial brief that, "The evidence from both the preliminary injunction hearing and the trial before this Court establishes two factual predicates for plaintiff's legal arguments. . . . Second, the evidence shows that, even if the Act were construed to prohibit only the D&E procedures in which the fetus is removed intact and the head is decompressed [the D&X procedure] it prohibits *a procedure likely to be as safe as other abortion methods*. . . . " Plaintiff's Post-Trial Brief at 11 (No. 4:97CV3205, D. Neb.) (April 16, 1998) (emphasis added). Thus, the findings of the district court as to the relative safety of the procedure inexplicably went far beyond what the Plaintiff/Respondent himself asserted.

11, the only significance of ***Danforth*** in this case is its reaffirmation of an important component of ***Roe v. Wade*** that is directly applicable here: "*In* ***Roe v. Wade*** the Court . . . emphatically rejected, however, the proffered argument 'that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses.' " ***Danforth,*** 428 U.S. at 60 (quoting ***Roe v. Wade,*** 410 U.S. 113, 153 (1973)) (emphasis added). The Respondent's proposed standard for health exceptions violates this portion of ***Roe.***

The Respondent insists that a health exception is a per se requirement for all statutes regulating abortion. Brief of Resp. at 47. Furthermore, the Respondent maintains that the applicable standard for maternal health considerations remains the "medical trade-off" test employed in ***Thornburgh v. American College of Obstetricians and Gynecologists,*** 476 U.S. 747 (1986), *overruled,* 505 U.S. 833 (1992). Brief of Resp. at 46-48. However, the ***Thornburgh*** "medical trade-off" standard is inconsistent with ***Casey,*** and cannot serve as a guide for what constitutes an "undue burden" since, for the reasons discussed below, its application would effectively prohibit all state regulation of abortion up to and including full-term birth.[2]

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[2] Some lower courts have erroneously concluded that a health exception is required in partial-birth abortion statutes whereby the procedure must be allowed whenever it is theoretically "safer" for the woman than alternative procedures. This is simply another way of asserting that, under the undue burden standard, the relevant inquiry is whether the D&X/ partial-birth abortion procedure is safer than available alternatives. This is an erroneous framing of the issue since the correct test is simply whether there are safe alternative procedures available. ***See, e.g., Mazurek v. Armstrong,*** 520 U.S. 968 (1997) (permitting States to ban non-physician abortions even though some physicians assistants may perform the

Application of a standard that absolutely bars any "trade-off" between maternal health and the well-being of the child would render this Court's decision in ***Casey*** meaningless as to its protection of the States' interests, as it would effectively institute abortion on demand. The State respectfully invites the Court to test this assertion and its underlying premises, discussed below.

The institution of abortion as an absolute right, up through and including full term delivery of a viable healthy child, is necessarily effectuated by the "trade-off" test. This is so because under this analytical framework, a state abortion regulation may never result in the subordination of a woman's "health" to that of the child at any time. The "health" of the woman is considered to be jeopardized or compromised whenever she is required to forego a procedure which would be "safer" than the remaining alternative procedures.

The problem with this approach can be seen in the fact that collapsing a child's skull, prior to the passage of the child's head from the uterus to the birth canal through the cervical os, may arguably make delivery faster and easier since the child's head has the widest diameter of any part of an infant. J.A. 49. If this were true, under the Respondent's proposed legal framework there would be no circumstances under which a State could prohibit any abortion, since even during the birth of a full-term viable healthy child it would be faster and allegedly "safer" for the mother if the doctor removed the brain and collapsed the child's skull before delivering the child's head. For a State to prohibit even such a ghastly and unnecessary procedure would thus result in an

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procedures as or more safely, and less expensively, than some physicians). **See *also Casey,*** 505 U.S. at 883 (upholding statute that resulted in delay in performance of abortions); Brief of Pet. at 33-34, 38. Thus, much of the "health exception" debate is actually an "undue burden" argument.

"impermissible trade-off" between the "health" of the woman and the child, and thereby create an "undue burden" on women by denying them the opportunity to reduce the size of their baby's skull and thereby receive the resulting "health benefits" and increased "safety."

Realizing the implications of the position now advocated by the Respondent herein, the Seventh Circuit concluded, "A requirement of a case-by-case 'health exception' to every statute concerning abortion would amount to a rule that no state may regulate any abortion procedure." ***Hope Clinic v. Ryan,*** 195 F.3d 857, 873 (7th Cir. 1999). In other words, the Respondent's proposed standard would effectively institute abortion on demand, in contradiction of the Court's stated intention in ***Roe v. Wade*** and ***Casey. See also Hope Clinic,*** 195 F.3d at 874 (noting that acceptance of the position now advocated by the Respondent herein "would amount to a rule that anything goes.").

The Respondent's proposed interpretation of the undue burden standard, under which any marginal decrease in risk to the mother (or in this case, alleged theoretical or potential decrease in risk) can justify abortion at any stage of development, flies in the face of ***Casey's*** conclusion that prior caselaw (**i.e. *Thornburgh***) "undervalues the State's interest in potential life." ***Casey,*** 505 U.S. at 873. While maternal safety is obviously the largest and most important factor which courts consider, it does not automatically trump all other considerations in marginal cases, as the Respondent argues. ***See Casey,*** 505 U.S. at 880 (upholding a statute which contained exceptions for medical emergencies that are effective only where the delay caused by the statute would result in "significant" threats to the life or health of the woman.). Moreover, the absence of a health exception clearly does not affect a "large fraction" of women obtaining partial-birth abortions. ***See*** Brief of Amici Curiae National Right to Life, et al. at 21-25.

In sum, if any "trade-off" between maternal "health" and the well being of the child is impermissible, and if collapsing a child's skull prior to delivery makes the delivery faster and allegedly "safer" for the mother, then it necessarily follows that we have abortion on demand up through and including full-term birth itself. The State of Nebraska, and indeed the majority of all States, as well as overwhelming majorities of both houses of Congress, are saying this is wrong. Abortion is not an absolute right. ***Roe v. Wade,*** 410 U.S. at 153.

IV. Proper Construction of Nebraska's Partial-Birth Abortion Statute Avoids Vagueness Concerns and Limits Application of the Statute to the D&X Procedure.

A. The Plain Terms of the Statute Distinguish the Banned Partial-Birth Abortion/D&X Procedure from D&E (Dismemberment) Abortions Due, Among Other Things, to the Requirement of a Separate and Distinct Procedure to Kill the Unborn Child After Partial Delivery.

The Respondent asserts that "The Act does not require, as the State now urges, that the procedure that kills the fetus be a separate death-causing procedure." Brief of Resp. at 23. "Adding such a requirement would entail impermissibly rewriting the Act." ***Id.***

The insistence of the Respondent that there is no "separate death-causing procedure" requirement in the statute is unfounded. In describing the banned procedure, the statute states two times, in plain English, "*partially delivers* vaginally a living unborn child ***before killing*** the unborn child *and completing the delivery.*" Neb. Rev. Stat. § 28-326(9) (emphasis added). Thus, the separate and distinct nature of the death-causing procedure ("*a procedure* that the person performing such procedure *knows will kill* the unborn child *and does kill* the unborn child") (emphasis added) is plain and unambiguous on

the face of the statute. *Id.* Similarly, the sequencing requirement (partial vaginal delivery of a living unborn child, followed by a separate death-causing procedure) is not reasonably subject to debate. It is clear on the face of the statute: "Partial-birth abortion means . . . partially delivers vaginally a living unborn child *before killing* the unborn child and completing the delivery." *Id. See also* Brief of Amicus Curiae State of Wisconsin at 15.

The elements of the banned method of abortion include the deliberate and intentional 1) partial delivery of a living unborn child vaginally for the purpose of performing a separate death-causing procedure; 2) killing the unborn child by the separate procedure after its partial-delivery; and 3) completing the delivery. In contrast to a D&E abortion, where "[c]ontinuing disarticulation of fetal parts eventually kills the fetus," Brief of Amicus Curiae ACOG at 5, the statute requires that the banned procedure entail "a procedure that the person performing such procedure *knows will kill* the unborn child *and does kill* the unborn child." Neb. Rev. Stat. § 28-326(9). No method of abortion except the D&X procedure meets these statutory criteria, and thus no other method of abortion is banned by the statute.[3]

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[3] The U.S. asserts that "The statute makes abortion illegal unless fetal demise occurs before any 'substantial portion' of the fetus emerges into the vagina." Brief of Amicus Curiae U.S. at 10 (emphasis added). This interpretation ignores the plain language of the statute. By its express terms, the only conduct that violates the statute is "deliberately and intentionally delivering into the vagina a living unborn child or a substantial portion thereof, for the purpose of performing a procedure that . . . will kill the unborn child and does kill the unborn child." Neb. Rev. Stat. § 28-326(9). *See* Brief of Pet. at 14. Thus, as discussed above, the partial delivery of a living unborn child must be for the purpose of performing a separate and subsequent death-causing procedure. *See* Brief of Pet. at 14; 16-18. The U.S. equates the language of the statute regarding the death-causing procedure with merely "causing fetal demise." Brief of Amicus Curiae U.S. at 11. This construction also ignores the plain language of the statute, not to mention basic considerations of federalism as reflected in rules of statutory construction and the doctrine of constitutional avoidance. *See* Brief of Amici Curiae States of Virginia, et al. The language which the U.S. uses to craft its broad reading of the statute cannot be read in such a manner due to the context created by other terms in the statute, as discussed in section IV.B, *infra*.

B. Any Ambiguity in Nebraska's Statute is Eliminated by Application of the Doctrine of Noscitur a Sociis.

The Eighth Circuit expressly found that the "medical description [of the D&X abortion procedure] is within the definition of partial-birth abortion contained in the Nebraska Statute. . . . " *Carhart v. Stenberg*, 192 F.3d 1142, 1145 (8th Cir. 1999) (Pet. App. 4-5). The disputed point before the Court is whether, as Respondent contends, the statute also encompasses the D&E (dismemberment) abortion procedure. The basis for the Respondent's argument is the alleged ambiguity of the phrase "substantial portion" in the statute's definition of "partially delivers vaginally a living unborn child before killing the unborn child."[4] Nebraska's statute provides: "For purposes of this subdivision, the term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for

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[4] The assertion of the Respondent that dismemberment in a D&E abortion takes place outside the uterus appears to be a semantical innovation designed to attack the statute. For example, Dr. Martin Haskell's D&X monograph states unequivocally that "Classic D&E is accomplished by dismembering the fetus inside the uterus with instruments and removing pieces through an adequately dilated cervix." Brief of Amici Curiae Congressman Canady, et al., at App. 2 (setting forth the Haskell D&X monograph in its entirety).

the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." Neb. Rev. Stat. 28-326(9).

When isolated from its context, the term "substantial portion" is clearly subject to varying interpretations. However, the Respondent's calculated attempt to undermine the statute on this basis violates basic canons of statutory construction. The term cannot properly be construed in isolation from the rest of the statute. In ***U. S. v. Morton,*** 467 U.S. 822, 828 (1984), the Court stated, "If we were to look at the words "competent jurisdiction" in isolation, we would concede that the statute is ambiguous. . . . We do not, however, construe statutory phrases in isolation; we read statutes as a whole." ***Id.*** This same holistic approach to reading the challenged statute is required by Nebraska law. ***Stenberg v. Moore,*** 602 N.W.2d 465, 472 (Neb. 1999) ("In construing a statute, a court must determine and give effect to the purpose and intent of the Legislature as ascertained from the entire language of the statute. . . . ").

As discussed in detail in the main Brief of Petitioners (pp. 13-21), the language of the statute when read in its entirety does not proscribe any method of abortion except the D&X procedure. Any ambiguity as to the meaning of "substantial portion" is eliminated by application of the rule of statutory construction known as *noscitur a sociis*:

> It is a familiar rule in the construction of terms to apply to them the meaning naturally attaching to them from their context. *Noscitur a sociis* is a rule of construction applicable to all written instruments. **Where any particular word is obscure or of doubtful meaning, taken by itself, its obscurity or doubt may be removed by reference to associated words. And the meaning of a term may be enlarged or restrained by reference to the object of the whole clause in which it is used.**

Wharton v. Wise, 153 U.S. 155, 169 (1894) (emphasis added). ***See also Gutierrez v. Ada,*** ___ U.S. ___, 120 S.Ct. 740, 744 (2000) ("words and people are known by their companions."); ***Gustafson v. Alloyd Co., Inc.,*** 513 U.S. 561, 575 (1995) ("This rule we rely upon to avoid ascribing to one word a meaning so broad that it is inconsistent with its accompanying words. . . . ").

Here, the term "substantial portion" is "restrained" from encompassing D&E (dismemberment) abortions "by reference to the object" of the statute: "partial-birth" abortion. ***Wharton,*** 153 U.S. at 169; ***Little Rock Family Planning Services, P.A. v. Jegley,*** 192 F.3d 794 (8th Cir. 1999) ("The term 'partial-birth' abortion . . . is *commonly understood* to refer to a *particular procedure* known as intact dilation and extraction (*D&X*).") (emphasis added). Any remaining doubt about the meaning of the term is resolved by reference to its companion terms which eliminate D&E from the statute's coverage. ***See*** Brief of Pet. at 15-21 (discussing the terms "partially delivers vaginally" and "procedure that . . . will kill the unborn child").[5]

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[5] The suction curettage procedure is eliminated by reference to the plain terms of the statute. "Partially delivers vaginally . . . before killing the unborn child" and "delivering into the vagina" cannot reasonably refer to suctioning an intact embryo or pieces of an unborn child through a plastic tube as alleged by the U.S. ***See*** Brief of U.S. at 12. It would indeed be absurd to conclude that passage of an embryo or unborn child through a tube, either whole or in pieces, constitutes "delivering into the vagina." The unborn child in such a procedure never even touches the birth canal itself and is certainly not delivered "into the vagina" in any rational sense. In light of the plain language of the statute requiring delivery "into the vagina," the argument of the Respondent and the U.S. that the statute bans suction curettage abortions is specious and demonstrates the strained nature of their statutory construction arguments in general.

As discussed in the main Brief of Petitioner at 25 n.10, if the Court, following oral argument, has any

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Likewise, an induction procedure does not entail delivering into the vagina a living unborn child for the purpose of killing the child and completing the delivery. The Respondent and his amici may claim cutting the umbilical cord is sufficient to satisfy the statute's requirements. However, the cutting of the umbilical cord is not a death causing procedure under the terms of the statute. The death causing procedure must occur after "partial vaginal delivery" and before "completing the delivery." Neb. Rev. Stat. § 28-326(9). In an induction, the cord may theoretically be cut before the procedure begins, *see, e.g.*, J.A. 57, or after the child is delivered. It is not practical to cut the cord after the child is partially delivered. *Id.*; J.A. 131-132. Furthermore, the scienter requirements in the statute exclude inductions.

A "head-first" procedure involving delivery of a living unborn child into the vagina followed by killing the child is not within the contemplation of the statute. The intent of the statute is to ban only the D&X procedure. Head-first delivery followed by a death-causing procedure is not a recognized procedure in any event. Once the head is through the cervical os, the whole child will quickly follow since the head has the largest diameter of any part of a newborn. J.A. 49. As Dr. Carhart admitted "Once you've passed the internal os of the cervix, then you're out." J.A. 106. Thus, there would be no medical reason to kill the child once the head is out, and there is no recognized medical procedure where this is done. Consequently, such a procedure, if it existed, would already be prohibited under current Nebraska law. Neb. Rev. Stat. § 28-336 (1995) ("The performing of an abortion by using anything other than accepted medical procedures is a Class IV felony."). The whole basis for the D&X procedure is that the head is sometimes too big to fit through the cervical os without additional dilation. Therefore, if the head is being punctured in a head-first presentation, it is being done by reaching into the uterus; not after delivery of a living unborn child or a substantial portion thereof into the birth canal. ***See*** J.A. 48 (skull is pierced by reaching "through the cervical os."). ***See also*** J.A. 271 (testimony of Respondent's witness

unresolved questions regarding the proper interpretation of the scope or application of the statute, the Court could certify those questions to the Nebraska Supreme Court.

C. The Respondent's Claimed Ignorance as to What Constitutes a D&X Abortion Does Not Make the Statute Vague.

The Respondent, as well as numerous other plaintiffs nation-wide, have spent the past several years telling federal courts that bans on partial-birth abortion are unconstitutional because they do not know what the term means. They insist there is no such procedure as partial-birth abortion, and that the proper medical term is "D&X abortion." Now, the Respondent tells this Court a ban on D&X abortion would be "equally vague." Brief of Resp. at 49 n.50. According to the Respondent, a ban on D&X abortions "leaves physicians to guess exactly which abortions are prohibited." ***Id.*** Thus, after having insisted throughout years of litigation that the D&X procedure is a medically-recognized, and medically-accepted abortion procedure, the Respondent now asserts a ban on D&X abortion "is too vague to pass constitutional muster, for it does not define with adequate precision what the State means by a 'D&X' abortion." Brief of Resp. at 29 n.35. This anticipated argument is one reason why the drafters of the statute did not expressly ban "D&X abortion," or "intact D&E abortion," but instead described the D&X procedure and labeled it with the descriptive term "partial-birth" abortion. Nonetheless, the D&X procedure is a distinctive abortion technique which is distinguishable from the D&E procedure and other abortion procedures.

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distinguishing a head-first procedure from a partial-birth abortion). The statute simply does not apply to such a procedure.

See Brief of Amici Curiae Association of American Physicians and Surgeons, et al. at 5-12 (discussion of the distinctive nature of the D&X procedure); Brief of Amicus Curiae State of Wisconsin at 4-15.

D. The Chief Law Officer of the State of Nebraska has Consistently Interpreted the Statute as Encompassing Only the D&X Procedure and Excluding the D&E Procedure.

The Respondent's characterization of the State's interpretation of the statute as having recently evolved is simply incorrect. *See, e.g.*, Brief of Resp. at 25 ("The Act, as most recently construed by the State, would prohibit Dr. Carhart from performing . . . the D&X procedure."). In support of his characterization, the Respondent repeatedly cites to a brief submitted to the district court at a preliminary injunction hearing in July of 1997. *See* Brief of Resp. at 18 n.22.

The brief in question is not in the record in this proceeding, and the meaning ascribed to the quoted statements is a gross mischaracterization. The Attorney General has long recognized that "partial-birth" abortion refers specifically to the D&X abortion procedure. *See* J.A. 545-548 (Op. Att'y Gen. No. 96043). The record in this case, both at the trial level and in the Eighth Circuit, is clear as to the State's construction of the statute. The chief law officer of the State has interpreted the statute as encompassing only the D&X procedure, and excluding the D&E procedure.[6] *Carhart v. Stenberg*, 192 F.3d 1142,

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[6] At the time of the preliminary injunction hearing, Dr. Carhart referred to the banned procedure as "Intact D&E," while the district court referred to the "Haskell D&X." There is no dispute that these terms are both encompassed by what is known medically as the D&X abortion procedure. *See* Brief of Amicus Curiae ACOG at 6 (acknowledging that "D&X," "intact D&X," and "intact D&E" are all interchangeable terms). *See also* Brief of Amici Curiae Association of American Physicians and Surgeons, et al. at 9-12, 28-30 (discussion of the development of the term "D&X").

1150 (8th Cir. 1999) (Eighth Circuit's statement that "The State argues that LB 23's ban on partial-birth abortion prohibits only the D&X procedure, and not the D&E."); Pet.App. 16; R.Tr. 28 (Eighth Cir. App. 296) (statement by the district court that "it's the State's position that D&E is not prohibited; D&X is prohibited").

E. The Court Should Adopt the Constitutional Avoidance Doctrine Corollaries Proposed by the Amici Curiae States.

The State of Virginia, joined by numerous other States as amici curiae, has proposed two corollaries to the doctrine of constitutional avoidance. The Court should adopt these corollaries in order to redress the failure of the lower federal courts to properly apply the doctrine of constitutional avoidance, so as to uphold fundamental aspects of the federal-state relationship. Brief of Amici Curiae States of Virginia, et al. at 20-29. *See also* Brief of Pet. at 23-28.

Application of the "Reasonable Jurist" Corollary and/or the "State Certification Corollary," would result in adoption of the State's narrow construction of the statute and reversal of the Eighth Circuit Court of Appeals. *See* Brief of Amici Curiae States of Virginia, et al. at 24-26. The Petitioners strongly urge the Court to adopt and apply these corollaries in order to preserve the proper role of the States in our Union and to ensure proper application of the doctrine of constitutional avoidance.

The present case is just the latest example of the need for this action by the Court. *See Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187, 218 (6th Cir. 1997) (Boggs, dissenting), *cert. den.*, 523 U.S. 1036 (1998) ("The

post-*Casey* history of abortion litigation in the lower courts is reminiscent of the classic recurring football drama of Charlie Brown and Lucy in the *Peanuts* comic strip. Lucy repeatedly assures Charlie Brown that he can kick the football, if only *this time* he gets it just right. Charlie Brown keeps trying, but Lucy never fails to pull the ball away at the last moment."). Contrary to basic tenets of federalism, as reflected in fundamental rules of statutory construction, Brief of Pet. at 24-26, the lower federal courts have all too often failed to give the States the benefit of the doubt in cases where plaintiffs claim confusion about abortion statutes. Only this Court can set the proper tone for appropriate deference to State legislation in this area.

CONCLUSION

Nebraska's ban on partial-birth/D&X abortion can reasonably be construed as not encompassing the more common D&E abortion procedure, thereby leaving women a safe alternative procedure and avoiding the creation of an undue burden on the right to choose whether to terminate a pregnancy. In accordance with cardinal rules of construction and fundamental principles of federalism, and in recognition of the State's legitimate interests, the Court should reverse the decisions below and affirm the authority of the Nebraska Legislature to ban the partial-birth abortion/D&X procedure.

Respectfully submitted,

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In the Supreme Court of the United States

DON STENBERG, ATTORNEY GENERAL OF NEBRASKA, ET AL., PETITIONERS

v.

LEROY CARHART

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENT

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QUESTION PRESENTED

Nebraska Revised Statutes Annotated Section 28-328(1) (Michie Supp. 1999) prohibits any "partial-birth abortion" except when "necessary to save the life of the mother," and § 28-326(9) defines "partial-birth abortion" as an "abortion procedure" in which a person "deliberately and intentionally deliver[s] into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." The question presented is whether this prohibition against "partial-birth abortion" unduly burdens the constitutional right of a woman to terminate a pregnancy, or is unconstitutionally vague.

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INTEREST OF THE UNITED STATES

Under certain circumstances where the federal government is responsible for an individual's medical care, the government will either provide or pay for abortion services. For example, the Indian Health Service (IHS) affords eligible individuals access to all health care services that an IHS facility has the capacity to provide and that a physician determines to be a medically appropriate course of treatment. In IHS facilities with the capacity to provide abortion services, eligible individuals are entitled to such services in cases of rape or incest, or when the pregnancy endangers the life of the woman. See 25 U.S.C. 1676; Pub. L. No. 106-113, App. D, § 509, 113 Stat. 1501A-274. Similarly, a pregnant inmate in the custody of the Bureau of Prisons (BOP) is entitled to abortion services at government expense when the pregnancy results from rape, or when the life of the woman would be endangered if the fetus were carried to term. See BOP Program Statement No. 6070.05 (Aug. 9, 1996). The Nebraska statute challenged in this case prohibits certain

methods of abortion even for victims of rape or incest, and indeed for some women with life-threatening conditions.[1] The challenged Nebraska statute, and similar statutes enacted in other States, could therefore affect the ability of the IHS and the BOP to provide or pay for abortion services for pregnant women for whose medical care they are responsible.

Under the Medicaid and Medicare programs, federal law guarantees payment for covered physician services, including abortion services in cases involving rape, incest, or endangerment of a woman's life. When the pregnancy results from rape or incest, Medicaid and Medicare will pay for abortion services even though the pregnancy may not endanger the woman's life. See 42 U.S.C. 1396a(a)(8), 1396a(a)(10)(A), 1396d(a)(5)(A), 1395k(a)(1), 1395x(s)(1), 1395y(a)(1)(A); H.R. Conf. Rep. No. 479, 106th Cong., 1st Sess. 569 (1999). Because, as noted above, the Nebraska provisions challenged in this case prohibit certain methods of abortion even for victims of rape or incest, and indeed for life-threatening conditions, the challenged provisions, and similar ones enacted by other States, could affect the ability of Medicaid and Medicare beneficiaries to obtain covered abortion services by the procedure that a physician determines to be the medically most appropriate abortion method for the individual woman.

In addition, both the 104th and the 105th Congresses passed, but the President vetoed, legislation to prohibit

[1] The statute permits "partial-birth abortion" only when *that procedure* is necessary to preserve the woman's life. See Neb. Rev. Stat. Ann. § 28-328(1) (Michie Supp. 1999). Thus, even when an abortion is necessary to save the woman's life, a physician may not use a method of abortion covered by the statute if some other method of abortion would also save her life, even if the alternative procedure would impose far greater health risks on the woman. See Pet. App. 70-71 (dissenting opinion of Chief Judge Posner in *Hope Clinic* v. *Ryan*, 195 F.3d 857 (7th Cir. 1999) (en banc), petitions for cert. pending, Nos. 99-1152, 99-1156 and 99-1177).

"partial-birth abortion" except where necessary to save the life of the woman. The President's vetoes were based in part on concerns about the constitutionality of the bills as passed by the Congress. Similar legislation has been introduced in the 106th Congress, and the framing of that legislation has turned in part on a perceived need to avoid constitutional objections. The United States therefore has an interest in the clarification of the constitutional principles that would govern federal legislation similar to the statutes under review in this case.

STATEMENT

1. In 1997, the Nebraska legislature enacted into law provisions prohibiting an abortion method referred to as "partial-birth abortion." The statute provides the following definition:

> Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. For purposes of this subdivision, the term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.

Neb. Rev. Stat. Ann. § 28-326(9) (Michie Supp. 1999). Section 28-328(1) further provides: "No partial-birth abortion shall be performed in this state, unless such procedure is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." The "intentional and knowing performance of an unlawful partial-birth

abortion" in violation of the law is made a felony, *id.* § 28-328(2), and prosecution may be brought by either the Attorney General or a county attorney, *id.* § 28-328(5). The pregnant woman on whom the "partial-birth abortion" is performed may not be held criminally responsible, but the physician may be prosecuted, *id.* § 28-328(3) and (4).

2. Shortly after passage, respondent brought suit in district court to enjoin the operation of the partial-birth abortion statute as unconstitutional. Respondent contended that the statute is unconstitutionally vague; that by its terms it prohibits even the most widely used abortion procedures, including conventional dilation and evacuation (D&E) and suction curettage; and that even if, as petitioners argued, the statute is limited to the dilation and extraction (D&X) method of abortion (also known as intact D&E), it nonetheless imposes an unconstitutional undue burden on the right of a woman to terminate her pregnancy.

The district court, after taking testimony from respondent and expert medical witnesses for both sides, concluded that the statute was unconstitutional as applied to respondent, in light of respondent's medical practice. Pet. Supp. App. 56-60, 87-88. The court declined to make a determination whether the statute is valid on its face. *Id.* at 53-56. The district court agreed with all three of respondent's contentions. First, it concluded that, even if the Nebraska statute bans the D&X procedure alone, it is unconstitutional as applied to respondent because, for at least 10-20 patients treated by respondent in a year, the D&X method is the safest available method of abortion. *Id.* at 60-62. Second, the district court concluded that the terms of the statute also restrict respondent from performing the conventional D&E procedure. *Id.* at 74-85. Third, it found the statute unconstitutionally vague insofar as its proscription of a method of abortion turns on whether the physician delivers a "substantial portion" of a fetus into the vagina. *Id.* at 86-87.

3. The court of appeals affirmed on the ground that the statute restricts conventional D&E abortion; it did not reach the other two bases for the district court's decision. Pet. App. 1-22.[2] Centrally, the court rejected petitioners' contention that the statute by its terms reaches only the D&X procedure, in which, as petitioners define it, a physician removes all of the intact fetus, except for its head, from the uterus into the vagina and then performs a procedure designed to bring about fetal demise. The crucial problem with that argument, the court stated, is that the ban also operates when the physician removes a "substantial portion" of a fetus into the vagina before fetal demise. "[I]f 'substantial portion' means an arm or a leg—and surely it must—then the ban created by [the law] encompasses both the D&E and the D&X procedures. * * * [I]n any sensible and ordinary reading of the word, a leg or arm is 'substantial.'" *Id.* at 16 (internal quotation marks omitted). Because the law, under the court of appeals' reading, "prohibit[s] the most common procedure for second-trimester abortions," the court found that it imposes "an undue burden on a woman's right to choose to have an abortion." *Id.* at 19.

SUMMARY OF ARGUMENT

Nebraska's statutory ban on "partial-birth abortion" is unconstitutional for three reasons.

First, as the court of appeals concluded, the statutory definition of partial-birth abortion, on its face, is so broad that it reaches the abortion procedure most commonly used in the second trimester of pregnancy, conventional dilation and evacuation (D&E). In some circumstances the statute may also reach the abortion procedure most often used in the first trimester of pregnancy, suction curettage. There is no

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[2] Although the district court had considered only the validity of the statute as applied to respondent, the court of appeals suggested that the facial validity of the statute was before it. See Pet. App. 15.

dispute that, if the Nebraska statute does in fact reach so far as to prohibit either conventional D&E or suction curettage, then it is unconstitutional. Although petitioners present various arguments to show that the Nebraska legislature actually intended to prohibit only one abortion procedure, dilation and extraction (D&X), those arguments lack a firm basis in the text of the challenged statute.

Petitioners argue that, under principles of federalism, the federal courts should accept as controlling the construction of the statute (as limited to D&X) offered by the Nebraska Attorney General. That argument is wide of the mark because the Nebraska Attorney General has not been delegated the responsibility for construing the ban, which is a criminal proscription enforceable in the courts, and even if the Nebraska Attorney General could limit his office's prosecutions under the statute to the D&X procedure, he could not control prosecutions under the statute by county attorneys, who are independent under state law. Petitioners also invoke the canon that courts should construe statutes to avoid constitutional doubt, but that principle is of little utility here, for the statute is not fairly susceptible of petitioners' construction. Even if it were, petitioners' construction would not avoid constitutional questions in this case, but would simply shift the grave constitutional issue to the question whether a ban on the D&X procedure, with an exception only to save the life of the woman, unduly burdens a woman's constitutional right to terminate a pregnancy.

Second, the statutory ban on partial-birth abortion is unconstitutionally vague. "Partial-birth abortion" is not a generally accepted medical term nor a term of art with common-law roots. Its reach, therefore, must be discerned by reference to the statutory definition accompanying the ban. But, contrary to petitioners' submission, that statutory definition provides no assurance that the ban is limited to the D&X procedure. Even if a reading of the ban as reaching conventional D&E and suction curettage is not compelled, the statute on its face is certainly readily susceptible of such a construction, and the statute gives no clear guidance as to which procedures are included within the ban and which are not. Further, because the conventional D&E and D&X procedures have features in common, it is particularly important that a criminal statute purporting to distinguish between the two define the proscribed behavior with clarity, which this statute does not do. Absent a definite and controlling construction of this criminal proscription by the courts, therefore, a physician considering whether to perform even more regularly used abortion procedures would proceed at considerable peril, given the uncertainty of the statute's reach. That uncertainty also creates a chilling effect on the exercise of constitutionally protected rights in this sensitive area.

Third, even if the statute's proscriptive reach is limited to the D&X procedure, the ban is unconstitutional because the statute fails to provide an exception to preserve the pregnant woman's health. The statute therefore prohibits the D&X method even when a physician concludes that that method is best suited to preserve the health of a particular woman. Indeed, this law is so broadly written that it prohibits the D&X method even when termination of a pregnancy is necessary to avoid serious adverse health consequences to the pregnant woman, and other methods would cause an increased risk of harm to her. Petitioners suggest that alternative abortion procedures remain available to pregnant women in such circumstances. But for at least some women, those other procedures would jeopardize their health. Conventional D&E, for example, may involve significantly greater risk of uterine perforation, and the labor-induction procedure also presents a greater risk of complications for some women. The ban therefore forces at least some pregnant women to forego a safer abortion method for one that would compromise their health. In so doing, it creates a substantial obstacle to obtaining an

abortion for the pregnant women for whom the statute is relevant.

ARGUMENT

A. Nebraska's Ban On Partial-Birth Abortion Proscribes The Abortion Procedures Most Widely Used Before Fetal Viability, And Is Therefore Unconstitutional

1. We begin with the principle that the Constitution protects the right of a woman to choose to terminate her pregnancy. See *Planned Parenthood* v. *Casey*, 505 U.S. 833, 870 (1992) (joint opinion). That right, an aspect of liberty protected by the Due Process Clause of the Fourteenth Amendment, means that "a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability." *Id.* at 879. Even after viability, the woman's "constitutional liberty * * * to have some freedom to terminate her pregnancy," *id.* at 869, is sufficiently weighty that a State may not prohibit abortion "where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Id.* at 879 (quoting *Roe* v. *Wade*, 410 U.S. 113, 164-165 (1973)); see also *id.* at 872 (under *Roe*, State may prohibit abortion after viability "provided the life or health of the mother is not at stake").

Casey also recognized that a State may, throughout a woman's pregnancy, seek to advance legitimate interests in the pregnant woman's health and safety and in "protecting the potentiality of human life." 505 U.S. at 875-876; see *id.* at 871. Before viability, however, the State's interest in the protection of potential life does not extend to unduly burdening the right of a woman to obtain an abortion should she so choose. Rather, it permits the State to enact regulations to ensure that the woman's choice is "thoughtful and informed," and that she understands that "there are philosophical and social arguments of great weight" on both sides of the abortion question. *Id.* at 872. Thus, "the State may take

measures to ensure that the woman's choice is informed," and may even seek to persuade a pregnant woman "to choose childbirth over abortion." *Id.* at 878.

The manner in which the State seeks to promote the interests recognized as legitimate in *Casey* must not so impinge on the woman's constitutional liberty as to create an "undue burden" on her right to choose to terminate her pregnancy. "A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." 505 U.S. at 877. Pursuant to that standard, a State may further its interest in potential life only with the purpose "to inform the woman's free choice, not hinder it," and may not advance even a permissible purpose in such a way that has an unduly restrictive effect on the woman's ability to choose to terminate her pregnancy. *Ibid.*; see also *id.* at 878.

2. Under the principles of *Casey*, the Nebraska provisions challenged in this case are unconstitutional. In examining the effect of the challenged statute on a woman's right to terminate her pregnancy, it is important to bear in mind that the statute applies throughout pregnancy. It is neither framed nor intended as a regulation of abortion procedures only after viability. Moreover, the abortion methods prohibited by the statute are all used prior to fetal viability and prior to the third trimester; this is true for the dilation and extraction (D&X) procedure—which all agree is banned by the statute—as well as the more widely used conventional dilation and evacuation (D&E) and suction curettage methods of abortion.[3]

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[3] Indeed, respondent testified that he generally performs D&X abortions only up to 20 weeks' gestation. After that point, when the woman's health so permits, he usually attempts, as part of the abortion procedure, to cause fetal demise inside the uterus. See Pet. Supp. App. 18-19.

The statute makes abortion illegal unless fetal demise occurs before any "substantial portion" of the fetus emerges into the vagina.[4] That restriction fails to take account of the medical fact that, in the most common methods of abortion currently used in the first and second trimester—conventional D&E and suction curettage—fetal demise in many cases does not occur prior to the removal of at least some part of the fetus into the vagina.[5] That medical fact carries significant constitutional implications for this case, for petitioners do not dispute that, if the statutory definition of "partial-birth abortion" does reach either conventional D&E or suction curettage, then it is unconstitutional, for it would unduly burden the ability of women to obtain abortion services.

The lower courts correctly concluded that Nebraska's statutory definition of "partial-birth abortion" is on its face so broad that it reaches the most common method of abortion in the second trimester of pregnancy, conventional D&E. See Pet. App. 16-17; Pet. Supp. App. 74-85. The challenged law prohibits any "partial-birth abortion" except where the procedure is necessary to save the life of the

[4] The statute does not appear to reflect a state interest in promoting fetal life. It does not prohibit abortion procedures in which fetal demise occurs inside the uterus, nor does it implicate the abortion procedures of hysterotomy and hysterectomy, in which the fetus is surgically removed from the uterus through an abdominal incision rather than through the vagina.

[5] In some circumstances, it is possible to perform an abortion by inducing fetal demise inside the uterus and then removing the fetal material from the uterus. The evidence in this case, however, established that this procedure is available only after 20 weeks' gestation. See Pet. Supp. App. 18-19, 59, 63. Ironically, therefore, the statute might have the effect of encouraging women to delay their abortions until after 20 weeks' gestation. The district court found that there is no maternal health benefit in forcing women to wait until after 20 weeks' gestation so that an abortion may be performed in that manner, and that there is "appreciable risk to maternal health in doing so." *Id.* at 63.

pregnant woman, Neb. Rev. Stat. Ann. § 28-328(1) (Michie Supp. 1999), and defines partial-birth abortion as follows:

> Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. For purposes of this subdivision, the term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.

Id. § 28-326(9).

This language on its face reaches the conventional D&E abortion procedure, which is used as early as the 13th week of pregnancy. See Pet. Supp. App. 9. The crucial language covers "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof," with the purpose of causing fetal demise. As the district court observed (*id.* at 76), "a surgeon cannot perform a standard D & E in the usual case" without delivering a substantial portion of the fetus into the vagina. The standard D&E operation involves inserting a forceps inside the uterus and pulling fetal tissue out of the uterus through the cervix into the vagina, emptying the uterus as safely as possible for the woman.[6] See *id.* at 12; J.A. 55. Fetal demise does not necessarily take place inside the uterus but rather may occur after a substantial portion of the fetus has been delivered from the uterus into the vagina. Pet. Supp. App. 12-13.

[6] To minimize the use of forceps inside the uterus and increase safety, physicians may "bring as much of the fetus into the vagina as possible when performing a D & E." *Eubanks* v. *Stengel*, 28 F. Supp. 2d 1024, 1035 (W.D. Ky. 1998), appeal pending, No. 98-6671 (6th Cir. argued Dec. 15, 1999).

The definition of partial-birth abortion in the Nebraska statute also appears to reach the abortion procedure most widely used in the first trimester (and most widely used overall), suction curettage, typically used from the 6th through the 12th week of pregnancy. See Pet. Supp. App. 7.[7] In that procedure, the cervix is dilated, a small tube (cannula) attached to a vacuum device is inserted through the vagina into the uterus, and vacuum suction is used to remove the fetus from the uterus. *Id.* at 8. The vacuum procedure itself causes fetal demise, which may occur after the fetus or embryo has passed from the uterus. See *id.* at 9, 28.

Because the challenged statute proscribes the conventional D&E and suction curettage methods of abortion, the most widely used abortion procedures before viability, the statute places an undue burden on the right of women to terminate pregnancy and is unconstitutional. Cf. *Planned Parenthood* v. *Danforth*, 428 U.S. 52, 77 (1976) (in holding ban on saline amniocentesis as form of abortion unconstitutional, Court stressed that the procedure was "employed in a substantial majority * * * of all post-first-trimester abortions").

3. Petitioners argue, however, that the Nebraska legislature intended the provisions challenged here to reach only the D&X procedure, and so the court of appeals' decision adopting a broader construction of the statutory language should be rejected. Pet. Br. 22-23. They also argue that, because the Attorney General prosecutes violations of the partial-birth abortion ban, the Court should defer to his

[7] Although the lower courts did not in this case reach the question whether the Nebraska statute bars suction curettage, the same panel of the court of appeals, in two other cases involving closely similar statutory proscriptions in Iowa and Arkansas, concluded that the language does reach suction curettage. See *Planned Parenthood* v. *Miller*, 195 F.3d 386, 389 (8th Cir. 1999), petition for cert. pending, No. 99-1112; *Little Rock Family Planning Servs., P.A.* v. *Jegley*, 192 F.3d 794, 798 (8th Cir. 1999).

limited construction of the statute as controlling (*id.* at 12-13), and that the Court should also adopt that limited construction in order to avoid constitutional doubts about the statute (*id.* at 24-28).

Of course, petitioners' interpretation of the statute "is of some importance and merits attention, for they are the officials charged with enforcement of the statute." *Bellotti* v. *Baird*, 428 U.S. 132, 143 (1976). Nevertheless, both lower courts have now construed the Nebraska statute before the Court, and both have found it to be significantly broader than petitioners suggest. This Court normally defers to an interpretation of state law that has been reached by two lower courts. See *Casey*, 505 U.S. at 880. In any event, the limited construction proffered by petitioners is unpersuasive because it lacks grounding in the text of the statute.

a. Petitioners first argue (Pet. 15-16) that the term "partial-birth abortion" is commonly understood to refer only to the D&X procedure. "Partial-birth abortion," however, is not a term recognized by the medical profession, see Pet. Supp. App. 5; J.A. 36, nor is it a term of art with a settled common law meaning. The Nebraska legislature therefore deemed it necessary to provide a statutory definition of the term. When a legislature defines a term in a statute, courts are obligated to follow that definition. *Meese* v. *Keene*, 481 U.S. 465, 484-485 (1987). And if petitioners were correct that the legislature intended the ban to cover only the dilation and extraction procedure, then one would have expected the legislature to have expressly defined "partial-birth abortion" to mean "dilation and extraction," which is a term with a discernable meaning known to the medical profession, see Pet. Supp. App. 15-16; J.A. 599-601, or simply to ban dilation and extraction *in haec verba*; yet the legislature did not do so.

Second, petitioners suggest (Pet. Br. 16-18) that the statute distinguishes between the overall abortion "procedure" regulated by the law and the separate and distinct

"procedure" by which the physician causes fetal demise. They argue that the D&X procedure differs from other abortion procedures because the process by which the contents of the fetal skull are removed by suction is a separate "procedure" within the overall abortion "procedure." The statutory language, however, does not support petitioners' submission that the legislature intended to distinguish between the two "procedures." Rather, the statute defines "partially delivers vaginally" to mean delivery of the fetus (or a substantial portion thereof) into the vagina *for the purpose of* performing a procedure to cause fetal demise, not *before* performing a procedure designed to do so. See Neb. Rev. Stat. Ann. § 28-326(9) (Michie Supp. 1999).

Finally, petitioners contend that the statute was intended to reach only the situation where the physician delivers all of the fetus, except for the head, into the vagina intact, before causing fetal demise, and therefore does not reach the conventional D&E procedure. Even if that reading were correct (and for the reasons given at pp. 10-13, *supra*, it is not), the ban would still in many cases reach suction curettage, which, because of the extremely small size of the fetus or embryo, often involves the removal of the fetus intact, and before fetal demise, into the vagina. See Pet. Supp. App. 9; J.A. 42, 44, 257, 259.

b. Petitioners further urge (Pet. Br. 28) that the courts should defer to their limited interpretation of the partial-birth abortion ban, under a "variation" of the administrative-law principle of *Chevron U.S.A. Inc.* v. *National Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984). That argument is inapposite for several reasons. First, Nebraska's ban is a criminal statute, enforceable through prosecutions in the courts. See Neb. Rev. Stat. Ann. § 28-328(2) (Michie Supp. 1999) (defining "intentional and knowing performance of an unlawful partial-birth abortion" as a felony). Thus, while the Nebraska prosecuting authorities undoubtedly have "a very specific responsibility to determine for [themselves] what this statute means, in order to decide when to prosecute," this Court has not held that the interpretation of a criminal statute by those charged with prosecuting offenses under it is entitled to deference. See *Crandon* v. *United States*, 494 U.S. 152, 177 (1990) (Scalia, J., concurring in the judgment).[8]

Second, the Nebraska Attorney General does not have exclusive authority to bring prosecutions under the partial-birth abortion statutes. The county attorneys of Nebraska also have such authority. See Neb. Rev. Stat. Ann. § 23-1201(1) (Michie 1999) (duty of county attorneys to bring

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[8] This case does not involve a situation where proscriptions in a statute administered by an agency may be enforced through both civil and criminal processes. Nebraska's partial-birth abortion statute provides that, upon the filing of a criminal charge for violation of the ban, the Attorney General shall also commence administrative delicensure proceedings against the physician charged with performing the allegedly unlawful abortion. Neb. Rev. Stat. Ann. § 28-328(5) (Michie Supp. 1999). In that delicensure proceeding, the physician is afforded the opportunity to demonstrate that the abortion was necessary to save the life of the pregnant woman, and it appears that the physician has the burden of proof on that issue, see *ibid.*, a feature of the statute that presents serious constitutional concerns in the criminal context, see *United States* v. *Vuitch*, 402 U.S. 62, 70-71 (1971). The Director of Regulation and Licensure is empowered to make findings on that question, and those findings are admissible at the criminal trial of the physician. Neb. Rev. Stat. Ann. § 28-328(5) (Michie Supp. 1999).

This limited administrative proceeding does not provide a basis for affording deference to petitioners' construction of the ban under principles similar to *Chevron*. The delicensure proceeding is essentially ancillary to the criminal trial. Moreover, it is far from clear that, at the delicensure proceeding, the physician has any opportunity to contend that the procedure was not a "partial-birth abortion" within the meaning of the statute, or that the Director of Regulation and Licensure is empowered to make a determination to that effect. In any event, even if the Director could in such a proceeding provide an administrative construction of the partial-birth abortion ban, the Nebraska courts plainly have primary authority to interpret that statute through the criminal process.

criminal prosecutions); *id.* § 28-328(5) (noting that county attorney may file criminal charges under partial-birth abortion statute). While the Attorney General has authority to "consult with and advise the county attorneys, when requested by them, in all criminal matters," *id.* § 84-205(3), it does not appear that the Attorney General may compel the county attorneys (who are independently elected, see *id.* § 32-522) to follow his interpretation of state criminal statutes in deciding whether to bring a criminal prosecution. Thus, even if the Attorney General's limited construction of the partial-birth abortion statute were binding in any future prosecutions brought by his office, there is no reason to believe that the county attorneys would be so bound.

c. Petitioners also argue that the courts should accept their construction of the partial-birth abortion statute under the principle that courts should adopt constructions of statutes that avoid casting doubt on the constitutionality of those statutes, where such a construction is reasonable. We of course have no disagreement with the proposition that, when a court is faced with two reasonable constructions of a statute, and one places the statute in constitutional doubt while the other avoids a constitutional question, the courts should adopt the latter. Indeed, this Court has followed that rule of construction in some of its prior abortion cases. See, *e.g.*, *Planned Parenthood Ass'n* v. *Ashcroft*, 462 U.S. 476, 493-494 (1983) (opinion of Powell, J.). But that canon operates only when the narrower construction of the statute is "fairly possible," and "[i]t is qualified by the proposition that avoidance of a difficulty will not be pressed to the point of disingenuous evasion." *Rust* v. *Sullivan*, 500 U.S. 173, 191 (1991) (internal quotation marks omitted); see also *Thornburgh* v. *American College of Obstetricians & Gynecologists*,

476 U.S. 747, 768-769 (1986).[9] For the reasons given above (pp. 10-13, *supra*), we do not believe it is "fairly possible" to restrict Nebraska's ban to the D&X procedure.

Furthermore, even if we assume otherwise, the principle of avoiding constitutional doubt is still of limited utility here, for adopting petitioners' construction of the partial-birth abortion statute does not avoid a constitutional question; rather, it creates one. Cf. *Rust*, 500 U.S. at 191 (observing, when choosing among proffered interpretations of a statute, that "it was likely that any set of regulations promulgated by the Secretary [to implement the statute] * * * would be challenged on constitutional grounds"). To be sure, the constitutional question created by petitioners' narrower construction of the Nebraska statute is somewhat different from that created by the broader construction reached by the court of appeals, which petitioners acknowledge would be unconstitutional (Pet. Br. 25 n.10). And the Court might well conclude that the Nebraska legislature should not be presumed to have adopted a statute that even the State's Attorney General would not defend against constitutional challenge.[10] But even if petitioners' construction were adopted, the statute would nonetheless present the grave constitutional question, addressed at pp. 22-30, *infra*, whether a ban on the D&X procedure—without any exception to preserve the health of the pregnant woman—constitutes an

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[9] *Thornburgh* v. *American College of Obstetricians & Gynecologists* was overruled in part on other grounds, relating to informed-consent and waiting-period requirements, in *Casey*, see 505 U.S. at 870.

[10] The district court observed, however, that the legislative history did not demonstrate that the Nebraska legislature intended to prohibit only the D&X procedure, and that the legislature may not have understood that the procedure "varies in only small ways from the standard D & E technique." Pet. Supp. App. 83.

undue burden on the woman's right to terminate her pregnancy.[11]

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[11] Although petitioners have not previously asked the federal courts to certify to the Nebraska Supreme Court the question whether the partial-birth abortion statute reaches any method of abortion other than the D&X method, and do not request such certification now (Pet. Br. 25 n.10), petitioners observe that this Court might find it useful to certify various questions to the Nebraska Supreme Court after oral argument (*ibid.*). This Court has expressed strong approval of the certification procedure, see *Arizonans for Official English* v. *Arizona*, 520 U.S. 43, 75-80 (1997), and has certified questions of statutory interpretation to state supreme courts when (as in this case) one proffered reading of a statute would be clearly unconstitutional whereas another reading would present different, but nonetheless substantial, constitutional questions. See *Virginia* v. *American Booksellers Ass'n*, 484 U.S. 383, 393-394 (1988); *Bellotti* v. *Baird*, 428 U.S. at 144-146. Such certification, if it clarifies the scope of the statute under review here, could significantly assist the Court's task in adjudicating the constitutionality of that statute.

We note, however, some potential drawbacks to certification in this case. First, the Court also has pending certiorari petitions presenting the question of the constitutionality of similarly worded statutes in Iowa, Illinois, and Wisconsin. See *Miller* v. *Planned Parenthood*, No. 99-1112 (filed Dec. 23, 1999) (Iowa); *Hope Clinic* v. *Ryan*, No. 99-1152 (filed Jan. 10, 2000) (Illinois); *Planned Parenthood* v. *Doyle*, No. 99-1156 (filed Jan. 10, 2000) (Wisconsin); *Christensen* v. *Doyle*, No. 99-1177 (filed Jan. 14, 2000) (Wisconsin). The supreme courts of those States would not necessarily interpret their statutes in a manner identical to that adopted by the Supreme Court of Nebraska. Thus, even if the Nebraska Supreme Court were to issue a definitive ruling clarifying the scope of Nebraska's law, the Court would not necessarily avoid reaching some of the constitutional questions raised by that law in the present posture of this case, because the same questions might be presented in the Iowa, Illinois, or Wisconsin cases. Second, respondent's vagueness objections to the Nebraska statute include the contentions that the statute does not give fair warning of the scope of its proscription, and that several kinds of procedures other than the D&X procedure might fall within its scope. In this circumstance, certification may be less useful, because "no single adjudication [by the state supreme court] could eliminate the constitutional difficulty. Rather it would require extensive adjudications, under the impact of a variety of factual situations, to bring the challenged statute * * * within the

B. The Nebraska Statute Is Unconstitutionally Vague

Our discussion above shows that the statute under challenge reaches abortion procedures other than what petitioners contend to be its principal target, the D&X procedure. It may be argued that a broad reading of the statute is not *compelled*. But even so, the statute is certainly readily susceptible of an interpretation that gives it a scope far broader than petitioners suggest. That being so, the statute presents serious problems of fair notice, for it fails to differentiate with adequate precision the procedures that are within its reach from those that are not.

It bears emphasis that the provision under review is a criminal statute touching on sensitive constitutional rights. In that context, the need for precision is particularly great, for uncertainty about the scope of permissible conduct may deter activity that is constitutionally protected, but nonetheless arguably falls within the reach of the criminal proscription. See *Colautti* v. *Franklin*, 439 U.S. 379, 390-391 (1979), limited in part on other grounds, *Webster* v. *Reproductive Health Servs.*, 492 U.S. 490, 516-521 (1989) (opinion of Rehnquist, C.J.); see also *Baggett* v. *Bullitt*, 377 U.S. 360, 379 (1964). The matter must be viewed from the perspective of a physician attempting to decide whether an abortion procedure he or she has determined to be medically most appropriate would, or would not, render the physician liable to criminal prosecution: Does the Nebraska statute provide a physician about to perform a particular procedure with sufficient guidance so that the doctor can know whether the procedure is lawful?

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bounds of permissible constitutional certainty." *Procunier* v. *Martinez*, 416 U.S. 396, 401 n.5 (1974) (internal quotation marks omitted) (referring to abstention), overruled in part on other grounds, *Thornburgh* v. *Abbott*, 490 U.S. 401 (1989); see also *Baggett* v. *Bullitt*, 377 U.S. 360, 376-378 (1964) (also abstention).

In our view it does not. Rather, it "conditions potential criminal liability on confusing and ambiguous criteria." *Colautti*, 439 U.S. at 394. As we have noted, "partial-birth abortion" does not have a medically or historically rooted meaning. The Nebraska legislature undertook to define it, but the legislature's definition is highly problematic. One aspect of the problem is that the ban operates whenever the doctor delivers a fetus, "or a substantial portion thereof," into the vagina. Neb. Rev. Stat. Ann. § 28-326(9) (Michie Supp. 1999). No guidance is provided as to what constitutes a "substantial portion" of a fetus. Petitioners suggest that the statute applies only when all but the head of the fetus has passed through the cervix prior to fetal demise. The legislature did not, however, limit the statute to that specific situation. The physician, in conducting an abortion procedure, is therefore required to guess whether the extent to which a fetus has emerged from the uterus before fetal demise is sufficiently minimal to fall outside the statute's reach, or is substantial enough to constitute a crime.[12]

There is, moreover, a more basic problem presented by the statute: there are not always bright lines distinguishing one surgical abortion procedure from another. "Names are given to certain types of abortion methods, but each time

[12] The statute's reference to a "living" fetus also presents a serious vagueness problem. The statute punishes one who delivers a substantial portion of a living fetus into the vagina with the intention to cause fetal demise, and who then causes fetal demise. In many abortion procedures, however, it is uncertain when exactly fetal demise occurs. In both suction curettage and conventional D&E procedures, fetal demise does not necessarily occur immediately after the first part of the fetus is brought into the vagina. See J.A. 62-64; Pet. Supp. App. 19. Fetal demise may occur only after the doctor has removed the greater portion, and certainly a "substantial portion," of the fetus from the uterus into the vagina. See Pet. Supp. App. 29. In that situation, the doctor might find that he violated the statute even though he had no intention of removing the fetus *intact* before causing fetal demise, and in fact had not done so.

those methods are performed, their progression depends on the particulars of the physician and the patient. The physician cannot know, before the abortion begins, what steps will be necessary and she cannot know, during or after the abortion, where and when fetal demise occurs, unless the fetus is still living upon delivery." *Planned Parenthood* v. *Verniero*, 41 F. Supp. 2d 478, 494 (D.N.J. 1998). In addition, in some surgical situations, it may simply be impossible for the physician to control the portion of the fetus that is removed from the uterus, or the timing of that removal in relation to fetal demise. See J.A. 42, 151. For example, given the very small size of the fetus or embryo in early pregnancy, it is not clear that a physician conducting suction curettage could carry out the operation in such a way as to ensure fetal demise prior to the fetus emerging from the uterus intact.[13]

In all those situations, the physician would be placed in serious peril of criminal liability, for he might have delivered a "substantial portion" of the fetus into the vagina before bringing about fetal demise. In light of that peril and the minimal surgical distinctions among some abortion procedures, it is particularly essential that a statute regulating such a procedure state with clarity what is proscribed and what is permitted. Otherwise, many physicians might well decide to avoid performing abortions, a constitutionally protected activity, altogether. That is precisely the concern at which the vagueness doctrine is directed, and is sufficient reason to find the Nebraska statute invalid. See *Colautti*, 439 U.S. at 394, 396.[14]

[13] Suction curettage is performed as early as the sixth week of pregnancy, when the embryo is approximately 4-5 mm. in length. F. Gary Cunningham et al., *Williams Obstetrics* 152 (20th ed. 1997).

[14] The Court has also emphasized that vague statutes present a concern about arbitrary enforcement. See *City of Chicago* v. *Morales*, 527 U.S. 41, 60-64 (1999); *Kolender* v. *Lawson*, 461 U.S. 352, 357-358 (1983).

C. The Nebraska Statute Is Invalid Because, Even If It Is Clearly Limited To Dilation And Extraction, It Endangers The Health Of Some Women

Even if, contrary to our submission, the statute under review is clearly and definitely limited to the D&X procedure, it is nevertheless unconstitutional. Although the statute expressly permits the procedure when it is "necessary to save the life of the mother," Neb. Rev. Stat. Ann. § 28-328(1) (Michie Supp. 1999), it contains no exception at all to preserve the pregnant woman's health. Thus, the statute forbids the D&X procedure even when any alternative procedure would compromise the woman's health. This Court's decisions do not permit the State to subordinate a woman's health in that manner. Just as a State may not ban abortion when continuing the pregnancy would endanger a pregnant woman's health, see *Roe*, 410 U.S. at 165-166, and *Casey*, 505 U.S. at 879-880, so too a State may not restrict a particular method of abortion when so doing would endanger a woman's health, see *Thornburgh* v. *American College of Obstetricians & Gynecologists*, 476 U.S. at 768-769; *Danforth*, 428 U.S. at 79.

We recognize that petitioners have publicly taken the position that the statute under review will only be enforced against a physician who performs the D&X procedure. It may be that, if the Attorney General nonetheless brought a prosecution under the statute against a physician who performed a conventional D&E or suction curettage procedure, that physician might have a valid due process defense to such a prosecution, as he had previously been assured by petitioners that his conduct was lawful. But as we have explained (p. 16, *supra*), it is not evident that the Attorney General can bind independent county attorneys in the State to the same prosecutorial policy. Thus, in light of the expansive terminology used in the statute, a physician in Nebraska who performed a conventional D&E or suction curettage procedure would legitimately be concerned that such conduct could be prosecuted under the partial-birth abortion statute. Given the controversy that surrounds abortion, there is a legitimate concern that abortion providers might in the future be the target of arbitrary prosecutions. Cf. *Baggett*, 377 U.S. at 373-374.

1. From the outset, this Court has made clear that preservation of the woman's health is an integral part of the constitutional right to terminate a pregnancy.[15] Thus, in *Roe* itself, the Court observed that the decision whether to terminate a pregnancy may turn on "[s]pecific and direct harm medically diagnosable," 410 U.S. at 153, and held that even after viability, a State may not proscribe abortion "where it is necessary, in appropriate medical judgment, for the preservation of the life *or health* of the mother," *id.* at 165 (emphasis added). In *Doe* v. *Bolton*, 410 U.S. 179 (1973), the Court invalidated requirements that any abortion be performed in an accredited hospital, with approval by a hospital staff abortion committee, and with confirmation of the performing physician's judgment, based on his examination of the patient, by two other doctors. The Court stressed that the abortion-committee approval requirement substantially overbore "[t]he woman's right to receive medical care in accordance with her licensed physician's best judgment," *id.* at 197, and that a requirement of concurrence by two independent doctors, even after the attending physician had determined "based upon his best clinical judgment [that] an abortion [was] necessary" (*id.* at 191), had "no rational connection with a patient's needs," *id.* at 199.

The Court also has invalidated restrictions on particular abortion procedures when the restrictions required women to forego a safer method of abortion for one that imposed

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[15] Even before *Roe*, in *United States* v. *Vuitch*, 402 U.S. 62 (1971), the Court stressed that professional medical judgments are in fact, and are considered in law, important to the decision to terminate a pregnancy. There, the Court construed the District of Columbia's abortion statute, which prohibited abortions except where necessary to preserve the woman's "life or health," to place the burden of proof on the prosecution as to whether the abortion was so necessary. The Court stressed that "doctors are encouraged by society's expectations, by the strictures of malpractice law and by their own professional standards to give their patients such treatment as is necessary to preserve their health." *Id.* at 71.

increased health risks. In *Danforth*, where the Court invalidated a ban on abortion by saline amniocentesis as a method of abortion after the first 12 weeks of pregnancy, the Court stressed that, "as a practical matter, [the ban] forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." 428 U.S. at 79.

Even after viability, when the State's interest in regulating abortion is strongest, the Court has invalidated restrictions that would subject the pregnant woman to increased health risks. In *Colautti*, the Court held void for vagueness a requirement that a physician employ only that method of abortion that would most likely preserve fetal life, unless a different technique "would not be necessary in order to preserve the life or health of the mother." 439 U.S. at 397. The Court ruled that it was impermissibly uncertain under the statute whether the physician should consider his duty to the patient paramount to that of the fetus, or whether it required a "'trade-off' between the woman's health and additional percentage points of fetal survival." *Id.* at 400.

Likewise in *Thornburgh* v. *American College of Obstetricians & Gynecologists*, *supra*, the Court invalidated a requirement that a physician use the method that would most likely result in a live birth unless that method "would present a significantly greater medical risk to the life or health of the pregnant woman." 476 U.S. at 768. The Court concluded that the statute was "not susceptible to a construction that does not require the mother to bear an increased medical risk in order to save her viable fetus." *Id.* at 768-769.

This line of authority was not questioned in *Casey*. Indeed, in that decision, where the Court upheld informed-consent and waiting-period requirements except in cases of "medical emergency," the Court observed that the medical-emergency exception, which permitted an immediate abortion where "delay will create serious risk of substantial and

irreversible impairment of a major bodily function," did not (as had been contended) foreclose "the possibility of an immediate abortion despite some significant health risks." 505 U.S. at 879-880. Further, the Court stated, "[i]f the contention were correct [that the statute required delays that imposed health risks], we would be required to invalidate the restrictive operation of the provision, for the essential holding of *Roe* forbids a State to interfere with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." *Id.* at 880. Thus, because the State may not, in regulating methods of abortion, endanger a woman's health even after fetal viability, when the State's interest in protecting potential life is strongest (see *Thornburgh* v. *American College of Obstetricians & Gynecologists*, *supra*, and *Casey*, 505 U.S. at 879), *a fortiori* the State may not do so before viability.

2. Under these principles, the record establishes that the Nebraska statute is invalid. The Nebraska statute lacks any exception to preserve a pregnant woman's health. It requires some women to forego a safer method of abortion for one that escalates the risk to their health. This is an "undue burden" on the right to terminate a pregnancy, within the meaning of *Casey*. Whatever might be the State's interest in seeking to ban a particular method of abortion, such a restriction places a "substantial obstacle" in the path of the woman seeking to terminate a pregnancy, and is therefore impermissible under *Casey*, 505 U.S. at 877.[16]

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[16] In *Casey*, the Court made clear that the State may pursue two legitimate interests in regulating abortion: the health of the pregnant woman and the protection of potential life. 505 U.S. at 871. The statute under review, however, does not promote either of these interests (nor have petitioners argued that it does). Plainly it does not promote maternal health, for it may require women seeking abortions to undergo procedures that increase the risk to their health. And it does not protect potential life, for it prohibits only one method of abortion, and permits the woman to choose another, albeit possibly less safe, method to terminate

Petitioners argue (Pet. Br. 30-31, 35-36) that the statute nevertheless passes constitutional muster because women have available alternative methods of abortion, such as the D&E procedure and labor induction.[17] But even though those other procedures may be *generally* safe, in the sense that they satisfy a standard of medical care for the population at large, nonetheless for some women those procedures will be particularly risky. Those women, not the population at large, are the proper focus of the constitutional inquiry, for "[l]egislation is measured for consistency with the Constitution by its impact on those whose conduct it affects." *Casey*, 505 U.S. at 894.[18]

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the pregnancy. See Pet. App. 64-65 (dissenting opinion of Chief Judge Posner in *Hope Clinic*, *supra*).

[17] Petitioners observe (Pet. Br. 35) that neither the American Medical Association nor the American College of Obstetricians and Gynecologists (ACOG) has found the D&X procedure to be the *only* appropriate procedure sufficient to preserve the health of the woman. The ACOG policy statement cited by petitioners further states, however, that the D&X procedure "may be the *best* or *most appropriate* procedure in a particular circumstance to save the life or preserve the health of a woman," J.A. 601 (emphasis added)—that is, D&X may be medically superior to other procedures in particular cases, taking into account the need to avoid increased risks to the woman's health.

[18] Thus, in *Casey*, where the Court invalidated a prohibition against performing an abortion on a married woman unless she had notified her husband of her intent to undergo an abortion, the Court assumed that the great majority of married women would notify their husbands of their plans to have an abortion, but nonetheless held that the restriction was invalid because of its effect on the small but appreciable class of women who did not intend to notify their husbands of their intent to do so. See 505 U.S. at 894-895. Similarly, in *Bellotti* v. *Baird*, 443 U.S. 622 (1979), the Court invalidated as excessively restrictive Massachusetts' parental-consent and judicial bypass provisions governing abortions for minors. The provisions imposed an "undue burden" on a minor's right to terminate pregnancy, in part because they required that parents be notified of any effort by a minor to invoke the judicial bypass procedure. The lead opinion stressed that, although most parents would probably not obstruct a

Petitioners argue, for example, that the conventional D&E procedure is safe and routinely performed (Pet. Br. 36). But precisely because the D&E procedure is used for the overwhelming majority of second-trimester abortions, one must presume that women who have abortions by other methods do so for medically appropriate reasons. And indeed, the record shows that the conventional D&E procedure has significant risks for some women that are avoided by the D&X procedure. For example, conventional D&E requires the physician to introduce a forceps several times into the uterus. Each insertion of the forceps into the uterus carries a risk of uterine perforation or laceration. See Pet. Supp. App. 20, 109. That risk is largely absent in the D&X procedure, which involves much less use of surgical instruments inside the uterus. See J.A. 101-102, 121, 151-152, 268, 275. Particularly for a woman whose uterus is weakened by a previous medical condition, the D&X procedure may be more appropriate because it reduces the chance of further damage to the uterus.[19]

Petitioners also suggest that the labor induction procedure remains available as an alternative method of abortion. In the labor induction method, a physician inserts a needle through the woman's abdomen into the amniotic sac and introduces either a saline solution or urea followed by prostaglandin. Those chemicals are intended to cause fetal demise and induce uterine contractions, resulting in expul-

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minor child's right to go to court to obtain a judicial order permitting an abortion, some parents might do so, and the children of those parents needed an avenue of redress not subject to such obstruction. *Id.* at 647 (opinion of Powell, J.).

[19] In addition, the record establishes that the D&X procedure avoids several other complications associated with the conventional D&E procedure, such as lacerations from sharp bone fragments passing through the cervical os and the risk that fetal tissue remaining in the uterus could cause infection or hemorrhaging. Pet. Supp. App. 19-22, 62-63; J.A. 102-103, 151, 269, 277.

sion of the uterine contents. Pet. Supp. App. 24. Labor induction, however, involves considerable stress on the woman's body, must be performed in a hospital, and takes significantly more time than other abortion procedures. *Id.* at 24-25, 35; J.A. 69-70, 273-274. Further, labor induction is impossible for some women, such as those who are carrying a severely deformed fetus with hydrocephalus, where the head of the fetus may be too large to pass through the cervix. Pet. Supp. App. 35-36; J.A. 286. Labor induction is also medically inappropriate for some women with hypertension, heart disease, or diabetes, and for other women who may have reactions to the drugs used to induce the labor. Pet. Supp. App. 25; J.A. 69-70, 287; see also Pet. Supp. App. 147-148 (listing other risks from inductions).

Finally, in some cases, an abortion may be performed without running afoul of the statute by inducing fetal demise in the uterus through an injection of Lidocaine or Digoxin and then evacuating the contents of the uterus through the cervix, which has been dilated. Respondent testified that he attempts to use this procedure when it is possible. See J.A. 64-67, 110-113; Pet. Supp. App. 18-19. The procedure entails significant risks, however, because it requires introduction of a needle through the woman's abdomen into the uterine cavity, and the needle may carry bacteria from the bowel into the uterus, where it can cause infection. The needle can also break blood vessels and introduce chemicals into the pregnant woman's bloodstream. J.A. 291-292. The danger of perforating the bowel is particularly significant before 20 weeks' gestation, when the uterus has not grown large enough to push other structures out of the way; respondent, therefore, does not perform this procedure before that point. J.A. 66. The procedure is also contraindicated for some

woman (even after 20 weeks) who have seizure disorders and heart disease. J.A. 67, 113.[20]

3. It may be true that, if the D&X procedure were not available, some or even most women seeking an abortion in the second trimester would find another method available. But as the district court's findings make clear, for at least some women, those other methods will be appreciably less safe than the D&X procedure. Yet at the same time, requiring women to undergo those other methods of abortion does not advance any interest in either potential life or the health of the woman. Thus, a ban on the D&X procedure without any health exception will endanger the health of some women. That result constitutes an undue burden on those women's right to terminate their pregnancies.

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[20] In addition, hysterotomy (surgical removal of the fetus from the uterus through the abdomen rather than through the cervix into the vagina) and hysterectomy (surgical removal of the entire uterus) are available as methods of abortion in some circumstances, but they present significantly greater risk to the pregnant woman and are used only in exceptional circumstances. J.A. 281-282; Pet. Supp. App. 26. (Petitioners do not suggest that these methods of abortion are adequate alternatives to the D&X method.) Suction curettage cannot be performed after 15 weeks' gestation. Pet. Supp. App. 8. Respondent also testified that the labor induction method is inadvisable in the second trimester. J.A. 69-70. Therefore, at least between 15 and 20 weeks' gestation, only the D&E and D&X methods of abortion are generally available.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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No. 99-830

In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al., *Petitioners*,

v.

LEROY CARHART, M.D., *Respondent*.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

Motion for Leave to File and Brief of Amici Curiae Alabama, Iowa, Louisiana, New Jersey Legislature*, Pennsylvania, Virginia, South Carolina, South Dakota, Utah, and West Virginia Gov. Cecil Underwood in Support of Petitioners

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QUESTIONS PRESENTED

Amici Curiae request the Court to grant a writ of certiorari for the first two of Petitioners' questions, as summarized below. Amici Curiae do not believe that Petitioners' final two questions need be reached to resolve this case.

I. Whether the Eighth Circuit erred in broadly construing Nebraska's partial-birth abortion ban (unlike the Seventh Circuit's narrow construction of similar partial-birth abortion bans), thereby concluding that it reached conventional abortion methods, not just the intact D&X procedure?

II. Whether the Eighth Circuit erred by holding that Nebraska's law imposed an undue burden on the right to abortion?

MOTION FOR LEAVE TO FILE

Amici Curiae move for leave to file the attached Brief pursuant to Supreme Court Rule 37.2(b). The brief is presented on behalf of the States of Alabama, Iowa, Louisiana, Pennsylvania, South Carolina South Dakota, Utah, and Virginia, submitted by the States' Attorneys General, who are counsel on the Brief. If these Amici alone filed the present Brief, no consent for filing would be required under Supreme Court Rule 37.4.

The Brief is also presented by the New Jersey Legislature and West Virginia Governor Cecil H. Underwood, who have retained private counsel to defend their respective state laws restricting the practice of partial-birth abortion. The Clerk of this Court has instructed Counsel of Record that in the present situation a motion for leave to file is required.

Consent to the filing of this brief by the West Virginia "Governor and such attorneys general and other governmental entities (e.g., the New Jersey Legislature) as may wish to join the brief" was sought from the Nebraska Attorney General, on behalf of all Petitioners, and from Simon Heller, counsel for Respondent. (*See* consent letter, described next.) Consent was obtained from Petitioners, as evidenced by a letter signed by L. Steven Grasz, Deputy Nebraska Attorney General, filed with the Clerk. However, Mr. Heller denied consent.

Amici Curiae are States and state actors that have an interest in having this Court accept a partial-birth abortion case for review. Amici Curiae States have either enacted statutes restricting partial-birth abortion procedures or have an interest in enacting such a ban. The New Jersey Legislature and West Virginia Gov. Underwood are actively defending laws restricting partial-birth abortion that they helped to enact. All Amici have a general interest in seeing such laws upheld against constitutional attack so that they may be enforced.

This Brief has a unique perspective from that of the parties. It supports the Petitioners by explaining why the Court should grant their petition for a writ of certiorari, but it also demonstrates why the Court should only accept for review the first two of Petitioners' four questions presented.

The Brief provides other relevant matter not already brought to the Court's attention by the parties by providing the larger context for consideration of Nebraska's petition for this Court to accept review of its law restricting partial-birth abortion. The Brief does this by (1) providing the argument for the constitutionality of a partial-birth abortion restriction that was made in the United States Congress in 1995, when restrictions on partial-birth abortion were first proposed, especially the issue of when abortion jurisprudence ceases to govern matters relating to birth; (2) setting out the federalism concerns raised by court decisions in many partial-birth abortion cases with respect to issues of statutory construction, abstention, and the facial challenge standard of review; and (3) demonstrating how partial-birth abortion is a matter of great public interest by fully cataloging the state statutes restricting partial-birth abortion and the litigation involving the statutes.

For the foregoing reasons, Amici Curiae pray the Court to grant this Motion and accept for filing the attached Brief.

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BRIEF OF AMICI CURIAE

INTEREST OF AMICI CURIAE[1]

Amici Curiae are states and state actors that have an interest in having this Court accept a partial-birth abortion case for review. Most of Amici Curiae states have enacted statutes banning partial-birth abortion procedures. Over half of the states have enacted bans on partial-birth abortion. Some of these statutes are in effect, but others are under federal court injunction. The states have a strong interest in having bans against partial-birth abortion declared constitutionally permissible so that their own similarly-worded bans may be enforced.

SUMMARY OF THE ARGUMENT

Amici Curiae ask the Court to accept one or more partial-birth abortion cases for review, only requesting in the present case review of the first two questions presented by Petitioners Stenberg et al. concerning construction and undue burden. The partial-birth abortion issue is ripe for review because it is one of great national importance – as evidenced by the passing of partial-birth abortion bans in nearly three-fifths of the States, extensive litigation, and extensive congressional activity – and because of developed evidentiary records (the Nebraska and Wisconsin cases had full trials), polished arguments, and a conflict between the Seventh and Eighth Circuits.

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[1]Pursuant to Supreme Court Rule 37.6, Amici Curiae disclose that (1) no counsel for a party authored this brief in whole or in part and (2) no monetary contribution was made to the preparation or submission of this brief by any person or entity, other than the Amici Curiae, its members, or its counsel.

ARGUMENT

I. Amici Curiae Request Review of the First Two Questions Presented.

Petitioners Stenberg et al. presented four questions in their petition for a writ of certiorari. Amici Curiae believe this case can be resolved on the basis of the first two questions presented: (1) whether the Nebraska act should be narrowly construed so as to reach only a procedure known as intact D&X, and (2) whether, as so construed, the act imposes an undue burden on the right to abortion? Therefore, Petitioners' latter two questions need not be reached: (3) whether a human being delivered but for its head is a Fourteenth-Amendment person, and (4) whether the Court should now recognize abortion as a legislative issue?

The United States Court of Appeals for the Seventh Circuit recently upheld similar partial-birth abortion prohibitions in consolidated cases from Illinois and Wisconsin without having to reach issues (3) and (4) presented by Petitioners Stenberg et al. (These cases will soon be the subject of petitions for a writ of certiorari in this court, Justice Stevens having granted stays. *Planned Parenthood of Wis. v. Doyle*, 99A428 (U.S. Nov. 30, 1999) and *Hope Clinic v. Ryan*, 99A427 (U.S. Nov. 30, 1999) (orders staying mandate of Seventh Circuit)).

Similarly, the United States Court of Appeals for the Fourth Circuit stayed a Virginia district court's preliminary and permanent injunctions against enforcement of a similar partial-birth abortion statute without having to reach issues (3) and (4). *Richmond Med. Ctr. for Women v. Gilmore*, 144 F.3d 326 (4th Cir. 1998) (Luttig, J.), *aff'd*, 183 F.3d 303 (4th Cir. 1998) (staying prelim. injunction); *Richmond Med. Ctr. for Women v. Gilmore*, No. 98-1930(L) (4th Cir. Sept. 14, 1999) (order staying permanent injunction).

In fact, the federal partial-birth abortion ban bills, upon which Nebraska's ban and most other state bans are modeled, were premised in part on the belief that abortion jurisprudence does not even govern a statute involving partial-birth or parturition (but if it does govern then there is no "undue burden" on the abortion right). *See* H.R. Rep. No. 104-267, at 9 (1995)[2] (the report of the House Committee on the Judiciary recommending passage of Partial-Birth Abortion Ban Act of 1995); *The Partial Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the Sen. Comm. on the Judiciary*, 104th Cong., 1st Sess. 172 (Nov. 17, 1995) (written Testimony of Prof. Douglas W. Kmiec) (setting out basically the argument given herein). This understanding of the Constitution and this Court's decisions is discussed more fully below. As shall also be shown, partial-birth abortion bans may be readily upheld even within this Court's current abortion jurisprudence.

---

[2]The twelve-page report discussed the constitutionality of the partial-birth abortion ban under various levels of scrutiny. It declared that:

> The Supreme Court has never decided the constitutional status of a child in the process of being born. But even under *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, H.R. 1833, the "Partial-Birth Abortion Ban Act of 1995," is constitutional both before and after fetal viability. . . . In fact, in *Roe* the Court specifically noted that a Texas statute that made killing a child during the birth process a felony had not been challenged. . . . [H.R. Rep. No. 104-267, at 9.]

A. Serious federalism concerns are raised by the partial-birth abortion cases, including construction and the facial challenge standard.

The partial-birth abortion cases raise important federalism issues requiring resolution by this Court, including statutory construction and the facial challenge standard.

Under an appropriately narrow construction,[3] partial-birth abortion bans reach only one rarely-used procedure, intact D&X. Such limited bans pose no undue burden (even if abortion jurisprudence is applicable) because they have neither the purpose nor the effect of placing a substantial obstacle in the path of women seeking an abortion. Furthermore, the limited bans are amply justified by sufficient and indeed compelling state interests, including interests in protecting partially-born human life, erecting an impenetrable barrier against infanticide, and protecting maternal health, as well as a moral interest in preventing an especially offensive procedure.

However, the Eighth Circuit and numerous other federal courts have refused to adopt a narrow construction of partial-birth abortion statutes – refusing to show any deference to reasonable constructions offered by state enforcement authorities – and have instead adopted the untenable position that state legislatures had the purpose of banning virtually all common methods of abortion in open defiance of this Court's holdings

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[3]A threshold issue, not addressed by the Eighth Circuit, is whether federalism mandates that the state courts be afforded the first opportunity to give the new state statute an authoritative construction that may eliminate or narrow the federal constitutional issues presented here, under the doctrine of *Railroad Comm'n v. Pullman Co.*, 312 U.S. 496 (1941). While the Seventh Circuit was more sensitive to the demands of federalism, it too failed to address the advisability of *Pullman* abstention.

on abortion.[4] This Court has made it clear that it will not "cast a blind eye on over-reaching by lower federal courts" and "undoubtedly should" grant certiorari in order to prevent "blatant federal-court nullifications of state law" by means of "state-law determinations that seem plainly wrong." *Leavitt v. Jane L.*, 518 U.S. 137, 144-45 (1996).

The Fourth and Seventh Circuits have set the example of how a partial-birth statute ought to be construed, adopting narrow constructions under which only a procedure known as intact dilation and extraction[5] is prohibited. *Richmond Med.*

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[4]In accord with its concern for federalism, this Court has repeatedly indicated that the federal courts should accept a state's representations – whether sworn or unsworn, at oral argument or in memoranda, at the trial level or on appeal – as to the scope or meaning of a statute or ordinance. *E.g.*, *Forsyth County v. Nationalist Movement*, 505 U.S. 123, 131 (1992); *Ward v. Rock Against Racism*, 491 U.S. 781, 795-96 (1989); *Frisby v. Schultz*, 487 U.S. 474, 483 (1988); *Edwards v. Aguillard*, 482 U.S. 578, 595 (1987); *Hoffman Est. v. Flipside, Hoffman Est.*, 455 U.S. 489, 494 n.5 (1982); *DeFunis v. Odegaard*, 416 U.S. 312, 317 (1974). Federalism also mandates the presumption that the state legislature acted with knowledge of existing constitutional restrictions and did not intend to transgress those restrictions. *See, e.g., McDonald v. Board of Election Comm'rs*, 394 U.S. 802, 809 (1969).

[5]Intact dilation and extraction ("intact D&X") typically involves two days of cervical dilation to allow the trunk of a fetus to be extracted, followed by feet-first extraction of a living, post-20-week human being from the uterus until the head lodges in the cervical os, at which time the child's skull is punctured and the brain is suctioned out to collapse the head and permit extraction of the child.. *See Hope Clinic v. Ryan*, — F.3d —, 1999 WL 974098 at *2 (7th Cir. 1999) (upholding partial-birth abortion bans from Illinois and Wisconsin).

It is possible to conceive of variations of the intact D&X that the statutes would also ban (for example, where the partially-delivered child is killed by lethal injection rather than by brain suction). As a factual matter,

(continued...)

Ctr. for Women v. Gilmore, 144 F.3d 326 (4th Cir. 1998) (Luttig, J.), *aff'd*, 183 F.3d 303 (4th Cir. 1998) (staying prelim. injunction); *Richmond Med. Ctr. for Women v. Gilmore*, No. 98-1930(L) (4th Cir. Sept. 14, 1999) (order staying permanent injunction).

However, most other federal courts have, as one commentator noted (concerning a case involving an early statute designed to stop partial-birth abortion),

> crafted an opinion unconstrained by the Supreme Court's 'cardinal principle' [that federal courts must give state statutes a narrowing construction where reasonably possible to save them from constitutional assault] or any other standard of statutory interpretation. Rather, the opinion's only consistent interpretive principle is that standards of interpretation are selectively and temporarily employed and rejected to flout the Supreme Court's mandate and find the statute unconstitutional.

Comment, 112 Harv. L. Rev. 731 (1999) (discussing *Women's Med. Prof. Corp. v. Voinovich*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 523 U.S. 1036 (1998)).

Another key federalism issue is what standard should be applied to facial challenges to state statutes under the federal constitution. *United States v. Salerno*, 481 U.S. 739, 745 (1987), should apply to partial-birth abortion cases and plaintiffs should prevail only if they have demonstrated that there is "no set of circumstances under which the Act would be valid."

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[5](...continued)
such potential variations do not figure in this case or in currently recognized abortion practices and need not be distinguished from the intact D&X procedure described above. For purposes of this brief, these variations will be treated as subsumed under the term "intact D&X."

Id. Under the *Salerno* rule, their challenges must fail because they have clearly failed to demonstrate that the Act is unconstitutional under many circumstances, e.g., as applied to post-viability elective intact D&X abortions not done to preserve maternal life or health, or when there is clearly no demonstrable differential health benefit in performing such an abortion. Even if *Salerno* does not apply and partial-birth abortion laws are subject to the "undue burden" test of *Casey*, they do not impose a substantial obstacle to abortion for a large fraction of women for whom they are relevant. *Cf. Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 895 (1992).

This Court has not resolved under what circumstances the *Salerno* test should apply to challenges to abortion legislation. The circuit courts are badly divided on the issue,[6] as is this Court. *Ada v. Guam Society of Obstetricians & Gynecologists*, 506 U.S. 1011 (1992); *Fargo Women's Health Org. v. Schafer*, 507 U.S. 1013 (1993).

In the partial-birth abortion cases, the important issue of what standard to apply in facial challenges – especially those involving abortion – is at issue. A partial-birth abortion case would be an excellent vehicle for this Court to clarify the confused facial challenge issue. This is a vital federalism issue because federal courts are too readily striking down partial-birth abortion statutes with constitutional applications, depriving the states of the opportunity to construe and work out the meaning of their own statutes in the context of litigation involving real-life facts.

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[6]*Cf., e.g., Barnes v. Moore*, 970 F.2d 12 (5th Cir. 1992) (employing *Salerno* facial challenge test in abortion case) *with Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452 (8th. Cir. 1995) (not employing *Salerno* test in abortion case). *See also City of Chicago v. Morales*, 119 S. Ct. 1849 (1999).

B. The partial-birth abortion cases raise the issue of precisely when the waxing state interest in a child outweighs the waning abortion interest.

The second issue that this Court should consider in a partial-birth abortion case is whether the abortion right is burdened at all. As noted above, the partial-birth abortion laws were premised in part on the notion that abortion jurisprudence does not even apply to a partial-birth abortion statute because the constitutional equation has changed with the changed location of human offspring. The abortion right involves an "unborn" human being (not one partially born) and the termination of a pregnancy (which barely exists, if at all, when a child is partially delivered). Therefore, there could be no "undue burden" under a *Casey* analysis because a *Casey* analysis would not apply.

But even if some abortion interest remains when a child is partially born, what is the precise moment when the waxing state interest in the child outweighs the waning abortion interest? Three-fifths of the States now say by their partial-birth abortion bans that the constitutional balance tips when the fetus moves out of the womb and becomes a partially-born child.

That, then, is the overriding substantive issue of this case – one which this Court has not decided, as shown next. It is the issue this Court ought to decide: Does an abortion right apply in a partial-birth situation and, if so, when must it yield to a state's interest in the child?

In *Roe v. Wade*, 410 U.S. 113 (1973), this Court held that the Texas anti-abortion statute at issue was unconstitutional, but the Court also noted that another Texas statute that bans killing children in parturition was unchallenged and unaffected. As quoted by the Court, this statute provides as follows:

> Art. 1195. Destroying unborn child.—Whoever shall during parturition of the mother destroy the vitality or life in a child in a state of being born and before actual birth, which child would otherwise have been born alive, shall be confined in the penitentiary for life or for not less than five years.

Id. at 118 n.1.[7] The Texas parturition statute remains operative. Tex. Rev. Civ. Stat. Ann. art. § 4512.5 (West 1996). *See* Tex. Att'y Gen. Opinion H-369 (Aug. 13, 1974) (Texas parturition statute unaffected by *Roe)*; *Showery v. Texas*, 690 S.W.2d 689, 692 (Tex. Ct. App. 1985) (Texas parturition statute retains "current viability").[8]

The partial-birth abortion bans are based in part on the premise that states have a compelling interest in protecting the actual life of a child in the process of birth that is greater than, and distinguishable from, a state's interest in the "potential life" of a fetus in utero, which this Court has termed "substantial." *Casey*, 505 U.S. at 876. As the Wisconsin District Court found,

> when the physician kills a child in a partial birth abortion, the child "is merely inches from being delivered and obtaining full legal rights of personhood under the US Constitution." Accordingly, . . . partial birth abortion is "closer to infanticide than it is to abortion." The [Wisconsin State] legislators who filed an amicus brief [in the District Court] make similar arguments. The Court

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[7]"Parturition" is "the action or process of giving birth . . . ." *American Heritage College Dictionary* 997 (1993).

[8]The plain language of the Texas law requires only that the child in parturition "would otherwise have been born *alive*," not that the child be "*viable*." The partial-birth abortion statutes likewise are not limited to viable children.

concludes that these facts demonstrate that the Act serves compelling state interests.

Planned Parenthood of Wis. v. Doyle, 44 F. Supp. 2d 975, 982 (W.D. Wis. 1999) (citations omitted).

It logically follows from this Court's abortion decisions that the interest in protecting the life of the child in the process of birth arises from the change of legal status the fetus undergoes as she changes location, emerging from the maternal body toward complete birth. *Roe* affirmed the constitutional significance of the locational change that occurs as the child emerges from the maternal body. The child who has been completely born is a fully legal person, and the abortion liberty can make no claim on such a child's life. *Roe*, 410 U.S. at 156-57. Similarly, it follows that the child who is partially born is at least the subject of a compelling state interest, and any asserted abortion liberty holds, at most, diminished power over such a child.

"Birth" is "1.a. The emergence and separation of offspring from the body of the mother. b. The act or process of bearing young, parturition . . . ." *American Heritage College Dictionary* 141 (1993); "[t]he act of being born or wholly brought into separate existence." *Black's Law Dictionary* 154 (5th ed. 1979). "Born" is the "[a]ct of being delivered or expelled from mother's body, whether or not placenta has been separated or cord cut." *Id.* at 167.

A child who has fully emerged from the mother's body has obviously been "born" and is certainly a "person" who is the subject of compelling interests and the bearer of rights, as *Roe* recognized. But a child who is in the "process" of "being born," in the "act of being delivered," also falls within these common definitions. The state may properly conclude that such a child

is no longer "unborn" – no longer fully under the sway of the abortion liberty as described by *Roe* and *Casey*.

This Court has acknowledged that a state's interest in the life of a fetus grows as the fetus becomes able to survive apart from the mother's body – as the fetus becomes "viable." *Roe*, 410 U.S. at 163-64; *Casey*, 505 U.S. at 875-76. Likewise, a state's interest in protection of the life of an unborn child increases and becomes compelling as she emerges from the maternal body and proceeds toward full birth, reaching its apogee when live birth is completed. As the length of gestation has jurisprudential significance, so does location, and it is on the basis of the child's change in *location* that states assert a distinct compelling interest in protection of human life in the process of birth.

In the typical intact D&X abortion – the only procedure to which a properly construed partial-birth abortion statute applies – the child is delivered in a breech position, and only the child's head remains within the uterus. Much of the remainder of the child's body exists entirely outside the body of the woman. *See* Report of the AMA Board of Trustees ("One feature that distinguishes the D&X procedure from other destructive procedures is that the fetus may be partly outside the woman's body."). Surely, a state may conclude that such a child is no longer "unborn" and that the process of birth has proceeded to such a point that a state's interest in protection of the child has become compelling. "[T]he State cannot be faulted for acting where it can to outlaw an unnecessary procedure that in most cases in which it is used is literally inches away from being infanticide." *Doyle*, 44 F. Supp. 2d at 984.

Certainly, there is no precedent from this Court and there is no explicit language in the Constitution that precludes a state from determining that a child in the process of birth warrants

special protection as the subject of a compelling state interest. This Court has simply not addressed the issue.

Nor has this Court held that gestational development/viability are the *exclusive* criteria by which the Constitution allows the State to measure its interest in the protection of human life.[9] "Although abortion laws are typically justified according to the state's interest in maternal health or potential life, the *Casey* court specifically recognized that 'other valid state interest[s]' could justify a pre-viability abortion restriction.'" *Doyle*, 44 F. Supp. 2d at 983 (quoting *Casey*, 505 U.S.

[9]Lower courts which have rather summarily dismissed the claim that the State may maintain an enhanced interest in protection of the child in the process of birth have either erroneously regarded the gestational-development and viability criteria of *Roe* and *Casey* as exclusive or erroneously regarded the claim that locational criteria should be acknowledged as the addition of an unprecedented novelty to the analytic framework of *Roe* and *Casey*. *See Richmond Med. Ctr. for Women v. Gilmore*, 1999 WL 507453, at *35 (E.D. Va.) (July 16, 1999); *Causeway Med. Suite v. Foster*, 43 F. Supp. 2d 604, 615 (E.D. La. 1999); *Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1132 n. 48 (D. Neb. 1998) (incorporating *Carhart v. Stenberg*, 972 F. Supp. 507, 529 (D. Neb. 1997)); *Planned Parenthood of S. Ariz. v. Woods*, 982 F. Supp. 1369, 1377 (D. Ariz. 1997).

But these decisions are in error. First, as noted in text, this Court recognized that "other valid state interest[s]" might also justify pre-viability abortion restrictions. *Casey*, 505 U.S. at 877. Second, the locational criterion of birth is at the very core of the analytic framework of both *Roe* and *Casey*: The "right to abortion" applies only to "unborn" fetuses and has no claim on a child once birth is accomplished – when the child is not merely the subject of a compelling interest, but also a person and rights-bearer. Thus, although it is true that recognition of an enhanced state interest in the child in the process of birth elaborates and clarifies one element of *Roe/Casey* jurisprudence, it does not introduce an alien element into it.

at 877).[10] In fact, it would be absurd to posit that the mere potential to live outside the womb – viability – has constitutional significance, while the actual fact of emergence of a living child from the womb has none whatever.

In short, a state may assert a distinct compelling interest in the protection of children in the process of birth in support of the Act. This locational interest exists apart from the substantial and compelling interests that the State might properly assert in "potential" human life based on gestational development, and it warrants special protection of the partially-born child.

The fully born child – whether "viable" or not – is the subject of a most compelling interest in the protection of the child's life, based solely on the locational change the child has undergone. Likewise, the child in the process of birth – whether "viable" or not – is the subject of an enhanced state interest by virtue of the child's change in location.

Furthermore, the abortion right wanes as a state's interest in protecting a partially born child waxes. This Court has recognized only a right to terminate pregnancy. *Casey*, 505 U.S. at 847. This right authorizes a pregnant woman to seek the means to terminate her pregnancy without state interference that unduly burdens her decision. *Id.* at 876-77. What are the outer boundaries of this right? Certainly, they do not extend beyond

[10]"After a trial, the district court in the Wisconsin case concluded that the intact D&X procedure is never necessary from the perspective of the patient's health." *Hope Clinic v. Ryan*, 1999 WL 974098 at *14 (citing *Doyle*, 44 F. Supp. 2d at 979-82). Neither the American College of Obstetricians and Gynecologists nor the American Medical Association could identify any situations in which the intact D&X would be the only medically appropriate option. *Id.* The Seventh Circuit declared that "[w]e proceed on the assumption, which appears to be shared by the American Medical Association, that the D&X is not the best or safest option in any articulable category of situations." *Id.*

the maternal body. A woman seeking an abortion could not claim that this right authorizes killing a child who survives an abortion procedure and is born alive.

Partial-birth abortion bans also build upon this understanding of the abortion liberty. They acknowledge that pregnancy may be terminated under this Court's precedent, but deny that it may be terminated in a manner that purposefully seeks to kill the child once the child has begun the process of birth, a process marked by the passage of the living child's body from womb into birth canal to outside the woman's body. At this point, any claim of a right to terminate pregnancy is substantially obviated as pregnancy is terminated. The power and dominion of the abortion liberty diminish as its purpose is achieved and the child is delivered. Since the right to abortion does not include an independent right to assure fetal death, the abortion liberty cannot be asserted to justify a separate act to kill the child as the child proceeds out of the maternal body.

In sum, just as a state's interest in protection of the child increases as the child proceeds toward birth, the woman's right to abortion diminishes as the child leaves the maternal body. Partial-birth abortion bans do not prevent the termination of any pregnancy. They prevent killing a child after pregnancy has been terminated and the process of birth has been substantially completed.

Therefore, the abortion right is not even implicated in a parturition/partial-birth situation, so that this Court need not reach any issue related to the reconsideration of *Roe*. Even if a *Roe/Casey* analysis were appropriate, partial-birth abortion statutes should be upheld as marking the precise moment when the waxing state interest in protecting the partially-born child outweighs the waning interest in terminating a pregnancy. They should also be upheld as not constituting an undue burden because they leave in place safe alternatives to the only procedure that is banned under a proper construction of the statute, i.e., intact D&X, and because they promote other important state interests, such as maternal health.

This Court should accept review of a partial-birth abortion case to clarify this vital issue of the precise moment when any residual abortion right must yield to the interest a state protects when it outlaws infanticide. A majority of the States now say this happens during parturition, regardless of how the child arrives at its new location that transforms the constitutional equation.

II. A Partial-Birth Abortion Case Should Be Accepted for Review as a Matter of Great Public Interest.

The partial-birth abortion cases involve matters of great public interest, given that Congress has twice passed bills that were vetoed by President Clinton and only narrowly avoided being overridden. *See*, *e.g.*, Cong. Rec. S18228, roll call #596 (Dec. 7, 1995); Cong. Rec. H2929, roll call #94 (Mar. 28, 1996); Cong. Rec. H3338-3339, H. Doc. 104-198 (Apr. 10, 1996). Even now the issue remains alive in Congress, with the Senate recently passing a revised partial-birth abortion bill. (S.1692 passed 63-34, Oct. 21, 1999.) *See also* James Bopp, Jr. and Curtis R. Cook, *Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence*, 14 Issues in L. & Med. 3, 1998 (describing more fully the national history of the partial-birth abortion debate).

Following the lead of Congress, nearly three-fifths of the states have enacted some form of partial-birth abortion ban,

most patterned closely after either the 1995 or 1997 federal models.[11]

The passage of these state partial-birth abortion bans has led to extensive litigation in federal courts.[12]

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[11]Twenty-seven states have enacted statutes substantially similar to Nebraska's: Ala. Code §§ 26-23-1, 26-23-3 to 26-23-4 (1998); Alaska Stat. §§ 18.16.050 (Michie 1998); Ariz. Rev Stat. Ann. 13.3603.01 (West 1997); Ark. Code Ann. §§ 5-61-201 to 5-61-203 (Michie 1997); Fla. Stat. Ann. §§ 390.11, 390.0111 (West 1998); Ga. Code Ann. § 16-12-144 (1998); Idaho Code § 18-613 (1998); 720 Ill. Comp. Stat. 513/5-5, 513/5-10, 513/5-20 (West 1998); Ind. Code Ann. §§ 16-18-2-267.5, 16-34-2-1(b), 16-34-2-7(d) (Michie 1998); Iowa Code § 707.8A (1998); Ky. Rev. Stat. §§ 311.595(3), 311.720, 311.990(11) (Michie 1998); La. Rev. Stat. Ann. § 32.9 (West 1998); Michigan Senate Bill 546, P.A. 107 (1999) (signed July 7, 1999) (eff. date 90 days after closing of 1999 legislative session); Miss. Code Ann. §§ 411-41-71, 411-41-73 (1998); Missouri Senate Substitute No. 3 for House Bills Nos. 427, 40, 196 and 404 (1999), to be codified at Mo. Rev. Stat. § 565.300 et seq.; Mont. Code Ann. § 50-20-401, as amended by 1999 Mont Laws 479; Neb. Rev. Stat. Ann. §§ 28-326, 28-328, 71-148(15) (Michie 1997); N.J. Stat. Ann. §§ 2A:65A-5 to -7 (West 1997); N.D. Cent. Code §§ 14-02.6-01 to 14-02.6-03; Okla. Stat. tit. 21, § 684 (1998); R.I. Gen. Laws §§ 23-4.12-1, 23-4.12-2, 23-4.12-3, 23-4.12-4 (1998); S.C. Code Ann. §§ 44-41-85, 16-1-90(F) (Law Co-op 1997); S.D. Codified Laws §§ 34-23A, 34-23A-32 (Michie 1998); Tenn. Code Ann. § 39-15-209 (1997); Va. Code Ann. § 18.2-74.2 (Michie 1998); Wis. Stat. §§ 895.038, 940.16 (1997); W.Va. Code §§ 33-42-3, 33-42-8 (1998). Three other states have attempted to target intact D&X in statutes using different language. *See* Kansas Stat. Ann. § 65-6721 (1998); Ohio Rev. Code §§ 2919.15 to 2919.19, 2307.51, 2305.11(C) (1997); Utah Code Ann. § 76-7-310.5 (1999)

[12]Partial-birth legislation has been the subject of numerous final federal district and state trial court decisions. *Summit Med. Associates, P.C. v. James*, 984 F. Supp. 1404 (M.D. Ala. 1998) (question certified to Ala. S. Ct.); *Little Rock Family Planning Services, P.A. v. Jagley*, No. LR-C-97-581, 1999 WL 753928 (8th Cir. Sept. 24, 1999) (Ark.); *Planned Parenthood of Alaska v. State of Alaska*, No. 3AN-97-6019 CIV (Super. Ct. Mar. 13, 1998); *Planned Parenthood of S. Ariz. v. Woods*, 982 F. Supp. 1369 (D. (continued...)

Partial-birth type statutes have now been the subject of several final federal circuit court decisions. *Hope Clinic v. Ryan*, Nos. 98-1726, 99-2528, 99-2533, 1999 WL 974098 (7th Cir. Oct. 26, 1999) (Ill. and Wis.); *Carhart v. Stenberg*, Nos. 98-3245NE, 98-3300NE, 1999 WL 753919 (8th Cir. Sept. 24, 1999) (Neb.); *Planned Parenthood of Greater Iowa. v. Miller*, No. 99-1272SI, 1999 WL 753770 (8th Cir. Sept. 24, 1999) (Iowa); *Little Rock Family Planning Services, P.A. v. Jagely*, No. 99-1004EA, 1999 WL 753928 (8th Cir. Sept. 24, 1999) (Ark.); *Summit Med. Associates v. Pryor*, 180 F.3d 1326 (11th Cir. 1999) (Ala.) (limited to Eleventh Amendment issue); *Women's Med. Prof. Corp. v. Voinovich*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 523 U.S. 1036 (1998) (Ohio).

Moreover, there are presently five partial-birth abortion cases pending on appeal in federal courts of appeals. *Rhode Island Med. Society v. Whitehouse*, — F. Supp. 2d — , 1999 WL 683846 (D. R.I. 1999), *appeal docketed*, Nos. 99-2095, 99-

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[12](...continued)
Ariz. 1997); *A Choice for Women v. Butterworth*, 54 F. Supp. 2d 1148 (S.D. Fla. 1998); *Midtown Hosp. v. Miller*, 36 F. Supp. 2d 1360 (N.D. Ga. 1998) (approving consent order), *dismissed*, No. 1:97-CV-1786-JOF, by order entered Sept. 9, 1998); *Weyhrich v. Lance*, No. 1:98-CV-117 (D. Idaho Oct. 12, 1999); *Hope Clinic v. Ryan*, 995 F. Supp. 847 (N.D. Ill. 1998); *Planned Parenthood of Greater Iowa v. Miller*, 30 F. Supp. 2d 1157 (S.D. Iowa 1998); *Eubanks v. Stengel*, 28 F. Supp. 2d 1024 (W.D. Ky. 1998); *Causeway Med. Suite v. Foster*, 43 F. Supp. 2d 604 (E.D. La. 1999); *Evans v. Kelley*, 977 F. Supp. 1283 (E.D. Mich. 1997); *Intermountain Planned Parenthood v. Montana.*, No. BVD-97-477 (Mont. Dist. Ct. June 29, 1998); *Carhart v. Stenberg*, 11 F. Supp. 2d 1099 (D. Neb. 1998); *Women's Med. Prof. Corp. v. Voinovich*, 911 F. Supp. 1051 (S.D. Ohio 1994); *Planned Parenthood of Central N.J. v. Verniero*, 41 F. Supp. 2d 478 (D.N.J. 1998); *Rhode Island Med. Society v. Whitehouse*, 1999 WL 683846 (D. R.I. Aug. 30, 1999); *Richmond Med. Ctr. for Women v. Gilmore*, 51 F. Supp. 2d 441 (E.D. Va. 1999); *Planned Parenthood of Wis. v. Doyle*, 44 F. Supp. 2d 975 (W.D. Wis. 1999).

2141 (1st Cir. 1999) (proceedings stayed pending decision of a writ of certiorari in this case, Nov. 23, 1999); *Planned Parenthood of Central N.J. v. Verniero*, 41 F. Supp. 2d 478 (D. N.J. 1998), *appeal docketed*, No. 99-5042 (3d Cir. argued Nov. 19, 1999); *Richmond Med. Ctr. for Women v. Gilmore*, 55 F. Supp. 2d 441 (E.D. Va. 1999), *appeal docketed*, Nos. 98-930, 99-2000 (4th Cir. 1999); *Causeway Med. Suite v. Foster*, 43 F. Supp. 2d 604 (E.D. La. 1999), *appeal docketed*, No. 99-30324 (5th Cir. 1999); *Eubanks v. Stengel*, 28 F. Supp. 2d 1024 (W.D. Ky. 1998), *appeal docketed*, No.98-6671 (6th Cir. to be argued Dec. 15, 1999).

Two courts of appeals have now addressed the partial-birth abortion issue on the merits: the Eighth Circuit (represented by the present case) and the Seventh Circuit, *Hope Clinic v. Ryan* and *Christensen v. Doyle*, — F.3d —, 1999 WL 974098 (7th Cir. 1999) (upholding partial-birth abortion bans from Illinois and Wisconsin). The Fourth Circuit has also addressed the statutory construction issue in interlocutory orders staying the preliminary and permanent injunctions of a Virginia district court against implementation of the Virginia partial-birth abortion ban on the basis that as properly construed the statute bans only a procedure no plaintiff alleged doing, i.e., intact D&X. *Richmond Med. Ctr. for Women v. Gilmore*, 144 F.3d 326 (4th Cir. 1998), *aff'd*, 183 F.3d 303 (4th Cir. 1998) (staying prelim. injunction); *Richmond Med. Ctr. for Women v. Gilmore*, No. 98-1930(L) (4th Cir. Sept. 14, 1999) (order staying permanent injunction).

This issue is now ripe for this Court's resolution.

III. A Partial-Birth Abortion Case Should Be Accepted for Review Due to Conflict Between the Circuits.

A partial-birth abortion case is now ripe for review because there has been extended record development (with full trials in the Nebraska and Wisconsin cases), full development of the arguments through extended briefing, and a conflict between the Eighth Circuit (this case) and the Seventh Circuit. *Hope Clinic v. Ryan* and *Christensen v. Doyle*, — F.3d —, 1999 WL 974098 (7th Cir. 1999) (upholding partial-birth abortion bans from Illinois and Wisconsin).

CONCLUSION

For the foregoing reasons, Amici Curiae request the Court to accept one or more partial-birth abortion cases for review, requesting in the present case only review of the two questions set out at the beginning of the present brief.

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IN THE

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, *et al.*,
Petitioners,

v.

LEROY CARHART, M.D.,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF OF FAMILY RESEARCH COUNCIL AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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INTEREST OF AMICUS CURIAE

The Family Research Council is a non-profit public policy organization dedicated to preserving the integrity of the family and protecting the interests of mothers and children in the context of abortion. Our legal policy experts are continually sought out by federal and state legislators for assistance and advice on abortion and related issues. The Family Research Council has participated in numerous *amicus curiae* briefs in the United States Supreme Court and federal courts on the subject of abortion. Our research on current medical and legal issues surrounding abortion enables us to provide unique assistance to courts in cases such as this.

This brief is submitted with the written consent of all parties. No person or entity other than Family Research Council, its supporters, or its counsel has made a monetary contribution to the preparation or submission of this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case squarely presents the question of where abortion ends and infanticide begins. Family Research Council respectfully submits that the interest advanced by partial birth abortion bans such as Nebraska's is the clear demarcation between infanticide and abortion. Indeed, it is precisely because the practice of partial birth abortion blurs that

distinction for many that lawmakers find it necessary to ban the practice and denounce it publicly.

Family Research Council further submits that a plain reading of the ban shows that it governs only those abortions performed on the child in the process of being born. It does not govern those abortions involving the delivery of *that child's body parts* (for example, conventional dismemberment techniques). Courts which have interpreted partial birth abortion bans more broadly have given undue weight to the self-interested and biased testimony of abortion practitioners who do not like any abortion laws, however carefully drafted.[1]

Because the law's interest in life is rational and compelling, and because its scope is limited (leaving alternative abortion procedures available), this Court can easily uphold Nebraska's partial birth abortion ban as a reasonable and necessary means of protecting neonatal and partially born human life.

ARGUMENT

I. NEBRASKA'S PARTIAL BIRTH ABORTION BAN AIMS TO PROTECT HUMAN LIFE, A

[1] Indeed, Ohio's law banning partial birth abortion used different and far more specific language than Nebraska's. But challengers to this law, *represented by the same counsel*, raised *the very same objections* of vagueness to this differently worded law. *Women's Medical Professional Corp. v. Voinovich*, 911 F. Supp. 1051 and 130 F. 3d 187 (1997)[hereafter *Voinovich*]. This strongly suggests that the challenges to partial birth abortion bans are grounded not so much in the statutory wording as in opposition to legal oversight of abortion generally.

LEGITIMATE AND COMPELLING STATE INTEREST.

The statute at issue in this case is Nebraska's ban on partial birth abortion, also known as LB 23, which defines partial birth abortion as follows:

> (9) Partial birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. Neb. Rev. Stat. Ann. Sec. 28-326(9)(1998 Supp.)[2]

Constitutional analysis of any statute requires recognition and understanding of the statute's aim, goal or interest. In enacting LB 23, Nebraska joined 29 states in an effort to protect human life generally, and neonatal human life in particular, specifically the newly and partially born human infant.[3]

The state's interest in protecting human life, both prenatal and neonatal, is uncontested, even in the

[2] The definition continues: "For purposes of this subdivision, the term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." Neb. Rev. Stat. Secs. 28-326, 28-328 (1998 Supp.)

[3] *See* Motion for Leave to File Brief of Amici Curiae (States) in *Stenberg, et al. v. Carhart*, in the Supreme Court of the Untied States, by Attorneys General and Bopp, Coleson, & Bostrom, at page 16 (list of states).

abortion context. This Court has affirmed the legitimacy and compelling nature of this goal. "[T]here is a substantial state interest in potential life throughout pregnancy." *Planned Parenthood v. Casey,* 505 U.S. 833 (1992)[hereafter *Casey*]. "The State has an interest in protecting the life of the unborn." *Id.* "The State has a legitimate interest in minimizing such offense [disrespect for human life]." *Id.*

Indeed, this Court has stated that American courts have given too little weight to this substantial interest in abortion cases. "It must be remembered that *Roe v. Wade* speaks with clarity in establishing not only the woman's liberty but also the State's important and legitimate interest in potential life ... That portion of the decision in *Roe* has been given too little acknowledgment and implementation." *Id.*

The legislative history of LB 23 confirms that legislators have acted to protect and safeguard human life. Senator Maurstad, the primary sponsor of LB 23, advocated its passage with the following:

> "The discussion before us is the practice of partial birth abortion. **This is a debate about human life** and **whether a partially-born human life deserves protection** under the laws of the State of Nebraska ... We, as elected representatives of the people of the state of Nebraska, have a duty **to protect innocent human life.**"[4] [emphasis added]

[4] Transcript of the Legislature of Nebraska by Transcriber's office, April 11, 1997, at 3956 (1640 of record of LB 23) and at 3957 (1641 of record of LB 23). At the federal level, and in state legislatures around the country, elected officials expressed the same general concern: "By voting to ban this procedure, we ... **restore a sense of humanity and dignity to our public life.**" [emphasis added], Senator Santorum, "Santorum Remains Hopeful about Partial Birth Abortion," Cong. Press Release, Oct. 21, 1999. "I recognize that the American people remain deeply divided on this issue [of abortion]. But where there is common ground, **we need to move forward and protect life.**" [emphasis added] Senator Ashcroft, "Ashcroft Supports Senate Bill to End Partial Birth Abortion," Cong. Press Release, April 30, 1999. "The government's role is to **protect its most vulnerable.**" *The Kansas City Star*, Quoting State Rep. Hartzler of Mo., "Abortion at Center of Attention," Sept. 16, 1999 at A1.

II. NEBRASKA'S PARTIAL BIRTH ABORTION BAN AIMS TO PROTECT PARTIALLY AND NEWLY BORN HUMAN INFANTS.

A. Are partial birth abortion bans reasonable?

The ability of citizens to protect human life (that is, the life of the child in pregnancy) in the abortion context is limited. This Court has construed the United States Constitution such that the option of abortion must remain available to American women without undue interference by law.[5] Banning one abortion method, unknown and unused by most in abortion practice, including seasoned abortion practitioners, on its face does not unduly interfere with the abortion option, since alternative methods remain available.[6]

[5] *Planned Parenthood v. Casey,* 505 U.S. 833 (1992).

[6] This Brief argues that this is the correct interpretation of the statute, notwithstanding court opinions saying the language is vague. *See* Text at 20-22. It is worth noting that many abortion proponents who now claim the statutory language is vague and therefore incomprehensible, have revealed that they understand what procedure the law targets. For example, the expert witnesses

But some Courts have focused precisely on the availability of alternative abortion procedures as evidence of the law's inadequacy to meet its stated goal (the protection of human life). If the child in pregnancy may be legally destroyed by other means, the argument goes, how does the elimination of one abortion method protect that child's life?

The dissenting opinion for the Seventh Circuit Court of Appeals in *The Hope Clinic, et al. v. Ryan*, 195 F.3d 857 (7th Cir. 1999) (en banc) [hereafter *Hope Clinic*], is an example of this type of criticism. There the minority opinion stated:

> "To understand the issue [facing the Court] requires understanding of the peculiar and questionable character of these statutes. They do not protect the lives of fetuses either directly or by seeking to persuade a woman to reconsider her decision to seek an abortion. For the statutes do not forbid the destruction of any class of fetuses, but merely criminalize a *method*

testifying against the ban in this case, Dr. Stanley Henshaw, testified that "to my knowledge, there are only a few doctors nationally who do large numbers of D&X abortions." Transcript of Preliminary Injunction Hearing at 78. ("D & X" refers to dilation and extraction, another term for the partial birth abortion method. "D & E" refers to dilation and evacuation, the term for more conventional dismemberment techniques of abortion). Counsel for Plaintiff has also indicated comprehension of the law in public statements: "The number of procedures that clearly meet the definition of partial birth abortion is very small, probably only 500 to 1,000 a year." Statement by the Center for Law and Reproductive Policy to *New York Times*, March 28, 1996.

> of abortion – they thus have *less* to recommend them than the antiabortion statutes invalidated in *Roe v. Wade*, 410 U.S. 113 (1973)." *Hope Clinic.*

The Court's minority proceeded to deem the law as irrational. *Id.*

The opinion also intimated that supporters of such legislation around the country acted in bad faith by passing such laws. *Id.* However, an extraordinary number of elected officials have supported partial birth abortion legislation such as Nebraska's, including many who generally support legal abortion.[7] It is unlikely that irrationality, ignorance and bad faith (or a combination thereof) should afflict so many lawmakers, of such different political persuasions, throughout so much of the country. Upon examination of the record, it is clear that legislators sought to protect human life from an abortion method that appeared to be more infanticide than abortion.

B. Partial birth abortion approximates infanticide.

Courts are correct to point out that all abortion methods, upon examination, are gruesome and violent.[8] Family Research Council has unambiguously

[7] This includes the majority of state legislators in 30 states, most of their Governors, as well as veto proof majorities in the United States House of Representatives and a majority in the United States Senate. *See also* Motion for Leave to File Brief of Amici Curiae, *supra* note 3 at page 15.

[8] *Women's Medical Professional Corp. v. Voinovich*, 911 F. Supp. 1051 (1995): "This Court fails to see how the [D & X] procedure is more cruel than the D & E procedure, which involves dismemberment of the fetus."

championed this view in its efforts to fight abortion and persuade Americans of its wrongfulness.[9] Still, the American public has reacted differently to the partial birth abortion method.[10]

The difference between partial birth abortion and conventional abortion techniques is the evident similarity between the partial birth abortion method and infanticide. Partial birth abortion destroys the human child in a visible, open and explicit way, moments before birth, while conventional abortion methods do not. This explains the different public reaction to it, and why even legislators supportive of legal abortion have voted in large numbers to ban it: All recognize that this abortion method, unlike others, involves killing a child who is in the birth canal, in the process of being born. This renders the procedure indistinguishable from infanticide.

Nebraska Senators, like elected officials throughout the country, understand that allowing

[9] *The Truth in Black and White*, Family Research Council, January 1999. ("Family Research Council acknowledges the fact that the dismemberment of a child within the womb is, of course, as much a violation of that child's human rights as stabbing the child's head when he or she is almost fully outside the womb. Every form of abortion involves the violent destruction of innocent human beings and is therefore an egregious wrong.")

[10] It should also be noted that citizens do not have the option of protecting the child from all abortion methods, given present abortion jurisprudence. "[Family Research Council is] aware that courts would probably invalidate laws providing [more widespread] protection, given current precedents of the United States Supreme Court. Precedent, however, does allow citizens to protect the human infant from abortions during the process of birth ..." *Id.*

partial birth abortion means inviting a slide into full-blown infanticide since, as one legislator said, the difference between the newly born infant and the partially born infant is a matter of mere inches.[11]

For example, LB 23 passed with only one dissenting vote. The link between the partial birth abortion method and infanticide was made explicit several times during legislative debate:

> "LB 23 does not prevent a woman from having an abortion. In fact, it may not prevent a single abortion. The purpose of LB 23 is to prevent an abortion procedure. *What LB 23 does prevent is near infanticide."*[12] [emphasis added]

> "It's hard for me to understand how [the procedure] can be justified ... *because the delivery is almost complete before the abortion ... before the child is killed.*[13] [emphasis added]

> *"It's a living baby,* and it's in such a far advanced stage of pregnancy, I think that's why so many of us, pro-choice and pro-life people both, have

[11] Rep. Bill Luetkenhaus of Missouri, as quoted in Bill Bell, "The Moment of Truth is Here for the Abortion Measure," *St. Louis Post Dispatch*, Sept. 12, 1999 at page A8.

[12] Opening Statement of Sen. Maurstad, Transcript of the Legislature of Nebraska by Transcriber's office, April 11, 1997, at 3958 (1642 of record of LB 23).

[13] Statement of Sen. Dierks, Transcript of the Legislature of Nebraska by Transcriber's office, April 11, 1997, at 3961 (1645 of record of LB 23).

kind of a shuddering feeling when you think of the procedure itself.[14] [emphasis added]

Similar views supported the veto-proof votes in the United States House of Representatives and the majority votes in the United States Senate.[15]

Senator Ashcroft: "I also want to share a word of caution with those claiming that a ban on partial birth abortion is unconstitutional. If they truly believe that outlawing this procedure is impermissibly vague, *the inevitable conclusion people will draw is that infanticide and abortion are indistinguishable.*[16] [emphasis added]

Senator Specter: "Partial birth abortion *crosses the line between abortion and infanticide.*"[17] [emphasis added]

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[14] Statement of Sen. Crosby, Transcript of the Legislature of Nebraska by Transcriber's office, April 11, 1997, at 6385 (1658 of record of LB 23).

[15] The U.S. House of Representatives and the U.S. Senate first voted to override President Clinton's veto of the federal *Partial Birth Abortion Ban Act* in September 1996 (Cong. Rec. H10642, roll call #422; (vote: 285 to 137); Cong. Rec. S11337-11361, S11366-11389, roll call #307 (vote: 58 to 40). The second override vote was in July and September of 1998 (Cong. Rec. H6212-6213, roll call #325 (vote: 296-132); Cong. Rec. S10564, roll call #277 (vote: 64-36).

[16] Sen. John Ashcroft, "Ashcroft Supports Senate Bill to End Partial Birth Abortion," Cong. Press Release, April 30, 1999.

[17] Sen. Arlen Specter ("an ardent advocate of abortion rights"), as quoted in "Santorum Vows to Keep Fighting for Late-Term Abortion Ban," Anick Jesnanum, Associated Press, September 18, 1998.

Senator Lott: "The linkage ... between abortion and infanticide has become all too clear with the practice of partial birth abortion." [18]

Senator Ben Nighthorse Campbell: "[Partial birth abortion] is an atrocity which is inflicted on a fetus so far along in its development, *it is nearly an infant. I am pro-choice*! I have a 100 percent voting record with the National Abortion Rights Action League. I do not consider this ... to be a choice issue."[19] [emphasis added]

State legislators expressed the same view:

Rep. Gary Simrill of South Carolina: "If you ever look into what the partial birth abortion is, clearly, it is infanticide. There is no question about it."[20]

Senator Posthumus of Michigan: "This practice of aborting a fully developed baby is so extreme that even some of the most liberal members of Congress oppose it."[21]

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[18] "Majority Leader Commits to Enactment of Partial Birth," Cong. Press Release, January 15, 1998.

[19] U.S. Senator Ben Nighthorse Campbell as quoted in "No Moral Support for Partial Birth Abortion," Ann Donnelly, *The Columbian* (Vancouver, WA), June 15, 1997 at page 11.

[20] As quoted in Sharyn Lucas, "Abortion Bill Bans Some Procedures, Sparks Emotion," *The Herald*, February 28, 1997 at page 1B.

[21] As quoted in "U.S. state bars partial birth abortion," Deutsche Presse-Agentur, June 14, 1996.

> Rep. Ray Allen of Texas: "It's fairly plain that partial-birth abortion is infanticide and it should be against the law."[22]

Indeed, in Missouri, legislators have re-named the ban the "Anti-Infanticide Act," with sponsors advocating it as a response to infant killing: "All this does is make it illegal to kill a baby while it is being born."[23]

In sum, many view partial birth abortion as *indistinguishable from infanticide*; or, at least so similar that it blurs a line that should be crystal clear (the line between abortion and infanticide). That is why partial birth abortion constitutes a much greater threat to the newly born human infant than traditional abortion practice.

III. AMERICANS PERCEIVE THAT INFANT HOMICIDE IS ON THE RISE AND DEMAND THAT A PROTECTIVE, LEGAL LINE BE DRAWN TO PREVENT KILLING OF THE HUMAN FETUS/INFANT ONCE HE OR SHE EMERGES FROM THE WOMB.

The concern among Nebraska legislators and others that human infants are at risk in American society today is valid. For instance, one leading scholar,

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[22] As quoted in "Abortion Foes Seek New Limits," *The Forth Worth Star*, January 18, 1998 at page 1.

[23] State Sen. Ted House, as quoted on House Bill 427 in "Senate Nullifies Abortion Bill Veto, Legislators Again Rebuff (Governor) Carnahan, Vote to Outlaw Late-Term Procedure," Will Sentell, *The Kansas City Star*, at page A1.

Bioethics Professor Peter Singer of Princeton University's Center for Human Values, has seriously argued that infanticide is morally acceptable and should be put into practice.[24]

A. Reports and studies show an increase in infant homicide.

The actual incidence of infanticide is growing. While the reporting of infant homicide is not uniform throughout the country and estimates vary with the diligence of state officials, the most recent and reliable studies show that the rate of infanticide is increasing.

The most recent and publicized study appeared in late 1998 in the New England Journal of Medicine. It was the largest examination of infant homicide ever conducted and showed a marked increase in the rate of infanticide.[25] Press coverage was dramatic (the *New York Times*, for example, announced "Infant Homicide Found to be Rising in U.S.").[26] These findings are in keeping with other sources' reporting on neonaticide, including FBI statistics, which show that the number of

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[24] Singer has contended that "the life of a fetus...is of no greater value than the life of a nonhuman animal at a similar level of rationality..." Singer contends that his arguments apply equally to newborn children. *Practical Ethics* (2d Ed., Cambridge Univ. Press), at page 169.

[25] Wissow, and Overpeck, et. al., "Risk Factors for Infant Homicide in the United States," *New England Journal of Medicine*, Oct. 22, 1998 at 1239-1241 and 1211-1216, respectively.

[26] *See* Gilbert,"Infant Homicide Found to be Rising in U.S.," *New York Times*, Oct. 27, 1998

children under a week old who are murdered has increased 92% since 1973.[27]

State authorities (who investigate and verify infant homicide cases) confirm the trend. One report in Texas stated: "The homicide rate for children less than a year old has been climbing steadily since 1979, from 4.86 per 100,000 babies to the current 11.6, which is higher than the country's overall murder rate of 10 persons per 100,000."[28] And while the numbers tend to fluctuate and vary with reporting practices, those involved affirm that "there has been a steady rise over time" in child deaths.[29]

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[27] As reported in Marc Peyser, "Death in a Dumpster," *Newsweek*, December 16, 1997.

[28] Ira J. Hadnot, "Au pair case spotlights shaken baby syndrome," *The Dallas Morning News*, 16 Nov 1997, iJ, detailing interview with prosecutors in Tarrant County, Texas.

[29] Elizabeth Simpson, "Group Reviews Child Deaths in Hopes of Finding Answers," The Virginia-Pilot, 20 April 1998, B1 (interviews with members of the Hampton Roads Child Fatality Review Team). Even with higher numbers of child fatalities, authorities confirm that numbers in official reporting systems (such as those compiled by State Departments of Health or State Criminal Divisions and then submitted to the Center for Health Statistics) are unreliable and drastically low. "[T]here is strong evidence that both homicides and fatal cases of child abuse are undercounted." Overpeck, et al., *supra* note 25. In fact, one study published in 1992 on the inaccurate reporting in Missouri prompted many states to establish "Child Fatality Review Teams" to review cases more thoroughly. ("Child maltreatment fatalities are drastically underreported as such in Missouri because of inadequate investigations, lack of information sharing between investigators and agencies, and reporting systems that fail to capture the contribution of maltreatment as a cause of death.") Ewigman, et al, "The Missouri Child Fatality Study: Underreporting of maltreatment Fatalities Among Children

B. Recent highly publicized infanticide cases reinforce the conviction that the problem is growing.

Press reports of infant killings are also on the rise, reinforcing the conviction among members of the public and elected officials that it is increasingly difficult to protect infant human life. A lexus search on infant homicide/killing, neonaticide and infanticide reveals that the number of newspaper accounts of infant killing increased more than tenfold since the 1970s.

Two recent cases, highly publicized and provoking strong public reaction, illustrated what many see as a complete disregard for human infant life. Amy S. Grossberg and Brian C. Peterson, two middle class college students, delivered their baby in a hotel room in Delaware and then threw the baby in an outside trash bin in 1996.[30] Melissa Drexler, an 18-year-old New Jersey woman, gave birth during her senior prom in the banquet hall's bathroom, then dropped the baby in a garbage can to return to the dance and finish

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Younger than Five Years of Age, 1983-1986," Pediatrics 1992; 91:330-7. The work of these Review Teams, however, slows down official reporting. This explains the stabilization in numbers appearing in homicide and child fatality tables dating from approximately 1993 onward (most notably in State reports to the National Center for Health Statistics).

[30] *State v. Amy S. Grossberg*, ID No. 9611007818; *State v. Brian C. Peterson*, Jr., ID No. 9611007811 (1996 Del. Super. Lexis 545), December 6, 1996.

her dinner.[31] Both incidents came on the heels of other, equally disturbing reports of infant killings by younger women.[32]

In addition, infant abandonment cases are becoming so commonplace in certain areas that at least eight states have, or are considering, legislation targeting the problem.[33] (In the Houston area alone, there were 13 cases of infant abandonment within a 10

[31] *State of New Jersey v. Melissa Drexler*, Case No. 97091673, Oct. 29, 1998.

[32] Patricia Pearson, *When She Was Bad* (Viking Penguin Group 1997), Chapter 3 (detailing the case of Amy Ellwood, an 18 year old from Long Island who delivered her baby in the shower, placed him in a garbage bag and then in a bucket, and then finally in a cooler in her car. That evening she dumped the baby and the cooler in a lake.). Person elaborates further on the baby killing trend in Suffolk County, New York: "A colleague of Ellwood's father watched his daughter, Loretta Campbell, plead innocent in Hempstead to charges of second-degree manslaughter for smothering a boy she'd given birth to on January 1, 1991 ... leaving him in a garbage bag. Two weeks earlier, a C.W. Post College sophomore had been charged with first-degree manslaughter for gagging her baby with toilet paper and dumping him in a dorm hallway garbage can. Then there was the twenty-one-year-old Uniondale woman who pled guilty to first-degree manslaughter for killing her newborn boy, and a twenty-year old Brentwood woman who threw her baby out the window, and an East Northport woman who left her infant to drown in the tub. Other babies in Suffolk County were found by the police, but never connected to those who destroyed them." *Id.* at 70.

[33] Those states are: Alabama (Child Abandonment Act , Code of Alabama 1975, Section 26-18-6.); California (S.B. No. 1368); Colorado (S.B. 00-1710; Georgia (H.B. 1261); Kentucky (H.B. 546 & 367; S. 188); Minnesota (S. F. No. 2615); Oklahoma (H.B. 2148) and Texas (H.B. 3423).

month period. [34]) These bills allow mothers to leave their babies at designated spots (fire stations or hospitals, for example).

Lenient sentencing is also seen as contributing to the loss of respect for life and a threat to human infants. For example, Amy Grossberg was sentenced to just 2 ½ years imprisonment after pleading guilty to manslaughter of her baby; Brian C. Peterson was sentenced to just two years. Melissa Drexler pleaded guilty to aggravated manslaughter, a plea agreement which renders her eligible for parole after just three years in prison.[35] These sentences are not exceptional. As one survey explained, "Due to a lack of evidence or inability to prove the mother's state of mind, some prosecutors decline to bring charges against a mother who kills her child. Furthermore, judges are known to provide leniency to mothers found guilty of killing their infants."[36] Tom Morgan, a member of the U.S. Advisory Board on Child Abuse and Neglect who spent two years studying child fatalities, stated:

[34] Jim Yardley & Angela Shah, "Houston Baffled By Rise in Baby Abandonment," *The Austin American Statesmen*, December 26, 1999 at page B1; Stacy A. Teicher, "Rescuing Babies From Abandonment," *The Christian Science Monitor*, January 24, 2000 at page 3.

[35] *State v. Grossberg* and *State v. Peterson* (*see supra* note 30), Sentencing Order, July 9, 1998. *See also* "Killing babies," *The Washington Post*, 11 July 1998 at A18 (editorial); Blaine Harden, "New Jersey 'Prom Mom' Accepts Plea Agreement; Woman Who Threw Newborn Into Trash at Dance Could be paroled in 3 years," 21 Aug. 1998 at A04.

[36] Brenda Barton, "When Murdering Hands Rock the Cradle: An Overview of America's Incoherent Treatment of Infanticidal Mothers," 51 SMU L.Rev. 591 (March / April 1998), at 606.

"Prosecutors all over the country will tell you that the easiest murder to get away with is the killing of an infant or small child by a parent or caretaker."[37]

Even publications not normally concerned with legal protection for the unborn have sounded the alarm. *The Washington Post*, upon reviewing infanticide cases (including serial killing by mothers) with lenient sentences, pronounced: "It is as though these babies are something less than real people and killing them is less than real murder."[38]

Such statements, along with the numerous reports of baby killing and abandonment cases, reinforce the public's accurate perception that legal protection for human beings during infancy should be stronger. The enactment of partial birth abortion bans throughout the country - that is, legislation that protects the human being as he or she emerges from the womb - is one legitimate response to the very real trend toward increased violence and abuse of both neonatal and partially born human life.

The specific practice of partial birth abortion, because of its recognized similarities to direct infant killing, has made this connection clear even to Americans normally supportive of legal abortion.

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[37] Found in Charles A. Phipps, "Responding to Child Homicide: A Statutory Proposal," 89 Crim. L. & Criminology 535 (Winter 1999), footnote 5.

[38] Editorial, "Killer Mom," *The Washington Post*, 2 July 1999 at A26.

IV. NEBRASKA'S PARTIAL BIRTH ABORTION BAN, CORRECTLY CONSTRUED, IS NECESSARY TO PROTECT PARTIALLY BORN HUMAN LIFE AND IS REASONABLE AS A MEANS OF PROTECTING NEWLY BORN HUMAN LIFE.

A. Substantive due process means that a law cannot use arbitrary means to meet legitimate or compelling state ends.

Substantive due process means that a law cannot use arbitrary means to meet state ends. The connection between the means and the end depends upon the nature of the constitutional interest threatened by the law's operation.

This case poses an issue that is completely different from that presented in typical abortion cases, since Nebraska's law does not regulate abortion generally.[39] It bans only one uncommon abortion method. Banning one uncommon abortion method does not adversely affect any constitutional interest in choosing abortion, since common methods remain available.

Because no constitutional interest is threatened, this Court should scrutinize Nebraska's ban less strictly

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[39] This was true of the statute at issue in *Roe v. Wade*, 410 U.S. 113 (1973)(Texas criminal statute governing abortion generally); as it was of the Missouri law in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989) (Mo. Rev. Stat.§§ 188.029 et al (1986)); and finally, of Pennsylvania's Abortion Control Act in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

than a standard abortion statute.[40] However, regardless of the standard of review, the interest advanced by Nebraska's partial birth abortion ban remains both legitimate and compelling (the protection of human life generally, and specifically the human child partially and newly born) and the means both rational and necessary.

B. Nebraska's ban, correctly interpreted, does not adversely affect any constitutional interest in choosing abortion.

1. *Nebraska's ban governs only partial birth abortion, not conventional dismemberment techniques.*

The scope of Nebraska's ban is a threshold matter before this Court. (As Assistant Attorney General, Steven Grasz, stated in Oral Argument before the Eight Circuit Court of Appeals: "Your Honors, if this Court believes that Nebraska's statute banning partial birth abortion also bans the D & E abortion procedure, then

[40] Traditional abortion jurisprudence offers a poor guide for evaluating a prohibition on one abortion method since most prior cases involved statutes seeking to regulate all abortions. *See* cases cited in footnote 39. This Court left intact (and parties never challenged) that provision of the Texas statute at issue in *Roe* which forbade abortions during delivery of the child ("during parturition"). See Tex. Civ. Stat. Ann. Art. 4512.5 (Vernon 1996); and *Roe*, 410 U.S. at 118, n.1. This has led others to argue that *Roe* and its progeny simply do not apply to abortions involving fetuses/infants as they emerge from the womb. *See* Brief of Amicus Curiae States of South Carolina, Idaho, Louisiana, Ohio, Pennsylvania, Rhode Island, South Dakota and Utah, filed in United States Court of Appeals for the Eighth Circuit, *Stenberg et. al v. Carhart*, at 4.

this is a simple case. The statute is unconstitutional."[41]) Traditional rules of statutory construction require that courts construe state laws so as to render them constitutional. *Postscript Enterprises, Inc. v. Whaley*, 658 F.2d 1249 at 1253 (8th Cir. 1981) ("A federal court is ... obliged to favor an interpretation which renders the statute constitutional."); and *Casbah, Inc. v. Thone*, 651 F.2d 551 (8th Cir. 1981) ("A federal court is obliged to ... presume a legislative intent to act within constitutional bounds.") Thus, where a court *can* interpret a law so that it is not vague or overbroad, it has a duty to do so.

Several courts have now shown that this can be done for partial birth abortion bans. *See Hope Clinic v.Ryan*, 195 F.3d 857 (7th Cir. 1999) (en banc); *Christensen v. Doyle*, WL 974098 (en banc); *Richmond Medical Center for Women, et. al. v. Gilmore*, 144 F.3d 326 (4th Cir. 1998) (allowing Virginia's partial birth abortion law to take effect) [hereafter *Richmond Medical Center]*; *Planned Parenthood of Wisconsin v. Doyle*, 975 F. Supp. 1177, No. 98-C-305 (W.D. Wis. 1998) (upholding Wisconsin's ban). *See also Summit Medical Associates v. James*, 984 F.Supp. 1404 (M.D. Ala. 1998) (partial upholding of Alabama partial birth abortion ban). These courts have declined to construe the statute beyond its plain meaning.

In the case at bar, the clear intent of the statute is to cover an abortion method where one "deliberately and intentionally" delivers "into the vagina a living unborn child, or a substantial portion thereof." Neb. Rev. Stat.

[41] Transcript of Oral Argument in the U.S. Court of Appeals for the Eighth Circuit, *Stenberg et al. v Carhart*, April 19, 1999.

Sec. 28-326, 328 (1998 Supp.). The construction of the sentence alone indicates that "substantial portion" is meant to approximate the entire "living unborn child," since the word "or" means the two terms are interchangeable. Thus, "substantial portion" cannot be a leg, or an arm, or any other *sole body part*, unless that part (or parts) was so substantial that it amounted to most of the child. As the Fourth Circuit Court of Appeals stated when construing a similar statute:

> "The statute prohibits only the delivery of the intact fetuses or substantial portions of intact fetuses. *It does not prohibit the extraction of dismembered body parts ...."*[42] *Richmond Medical Center* [emphasis added]

Finally, Courts should presume good faith on the part of elected officials enacting laws as well as the Attorneys General entrusted to enforce and defend them. Statements by Nebraska legislators as well as Nebraska's Attorney General are clear with respect to the scope of LB 23: It governs only the partial birth abortion method, not more conventional dismemberment techniques.[43]

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[42] The wording of Virginia's ban is substantially like the wording of Nebraska's: "Partial birth abortion is an abortion in which the person performing the abortion deliberately and intentionally delivers a living fetus or substantial portion thereof into the vagina for the purpose of performing a procedure the person knows will kill the fetus, performs the procedure, kills the fetus and completes the delivery." Va. Code Section 18.2-74.2(D) (1998).

[43] *See supra* notes 4, 12-14, and accompanying text.

2. *Partial birth abortions are uncommon; therefore, partial birth abortion bans do not threaten a woman's constitutional interest in choosing abortion.*

The targeted method is uncommon and unusual. Challengers to the ban do not contest this.[44] As one seasoned abortion practitioner stated: "I've never seen or heard of anyone in my professional career (of over 25 years) performing such a procedure or needing to perform [it]."[45] Accordingly, a ban on the method will not affect abortion practice or the constitutional liberty of a woman to choose abortion.

CONCLUSION

In sum, Nebraska's partial birth abortion ban has the compelling state interest of protecting the partially or newly born human being. The law is a rational and necessary means to serve that interest. Americans perceive partial birth abortion to be a more direct threat to the newborn human infant than conventional abortion (in *utero*) since it approximates infanticide and further hardens sensitivities to human life.

Because the ban is limited in scope, it does not interfere with a woman's constitutional right to choose abortion. Therefore, this Court can easily uphold LB 23 as constitutional and Family Research Council respectfully requests that this Court do so.

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[44] *See supra* note 6.

[45] Testimony of Dr. Harlan Giles, Transcript of bench trial *Richmond Medical Center v. Gilmore* at 338, ll. 23-25.

Respectfully submitted,

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IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1999

DONALD STENBERG, ATTORNEY GENERAL FOR
THE STATE OF NEBRASKA, ET AL, PETITIONERS

v.

LEROY CARHART, RESPONDENT

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

MOTION TO ALLOW COUNSEL TO REPRESENT CHILDREN UNBORN AND BORN ALIVE

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MOTION TO ALLOW COUNSEL TO REPRESENT CHILDREN UNBORN AND BORN ALIVE

The Court is moved to allow Alan Ernest to represent the children being killed by *Roe v. Wade*, 410 U.S. 113, as counsel or guardian ad litem. Since there will be no expense to the Court, this is effectively a motion to allow retained counsel.

INTEREST OF COUNSEL

Counsel will prove that the U.S. Constitution's guarantee of life to "any person," made in its Fifth and Fourteenth Amendments, does include the unborn.

SUMMARY OF ARGUMENT

The unborn have a legal right to be represented by counsel, and to be aided by all the procedures guaranteed by the Constitution, so counsel can prove that the U.S. Constitution's guarantee of life to "any person," made in its Fifth and Fourteenth Amendments, does include the unborn.

ARGUMENT

I.

THE COURT USED THE MOCK TRIALS TO EFFECT AND MAINTAIN ITS *ROE v. WADE* KILLINGS WHICH THE NUREMBERG TRIBUNAL CONDEMNED AS "NOT A JUDICIAL PROCEEDING BUT A MURDER."[1]

A. The Court Effected And Maintains Its *Roe v. Wade* Killings By Unconstitutionally Refusing To Allow Counsel To Represent The Unborn And Defend Their Constitutional Right To Life.

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[1] The Court's procedures are also described in the book by Alan Ernest, *Mass Murder Is Liberty: How The United States Is Ruled by the Decree MASS MURDER IS LIBERTY* 45-53 (1998).

Counsel did not especially represent the unborn in the U.S. District Court, or at any stage in *Roe v. Wade*. An original party objected that the unborn should be represented by counsel in the U.S. Supreme Court:

> "(T)he Court should have every benefit of a complete record and the representation of a guardian ad litem for that fetal entity and for its natural right to develop to birth." Petition for Rehearing 5, *Doe v. Bolton*, 410 U.S. 179 (1973), denied 410 U.S. 959 (1973).

But the Court refused to allow counsel to represent the unborn and defend their right to life under the U.S. Constitution. Thus the Court commenced its killings.

And the Court has maintained its killings by steadfastly refusing to allow counsel to represent the unborn, and defend their right to life under the Constitution.[2]

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[2] *Colautti v. Franklin*, 439 U.S. 379, motion to allow counsel for the unborn denied 437 U.S. 902; *Anders v. Floyd*, 440 U.S. 445, motion to allow counsel for the unborn denied 439 U.S. 890; *Bellotti v. Baird*, 443 U.S. 622, motion to allow counsel for the unborn denied 439 U.S. 1065; *Ashcroft v. Freiman*, affirmed 440 U.S. 941, motion to allow counsel for the unborn denied 440 U.S. 941; *United States v. Zbaraz*, 448 U.S. 358, motion to allow counsel for the unborn denied 444 U.S. 1030; *Harris v. McRae*, 448 U.S. 297, motion to allow counsel for the unborn denied 445 U.S. 941; *H.L. v. Matheson*, 450 U.S. 398, motion to allow counsel for the unborn denied 445 U.S. 959; *Simopoulos v. Virginia*, 462 U.S. 506, motion to allow counsel for the unborn denied 458 U.S. 1104; *Planned Parenthood of Kansas City v. Ashcroft*, 462 U.S. 476, motion to allow counsel for the unborn denied 458 U.S. 1104; *Akron Center for Reproductive Health v. Akron*, 462 U.S. 416, motion to allow counsel for the unborn denied 458 U.S. 1104; *Diamond v. Charles*, 476 U.S. 54, motion to allow counsel for the unborn denied 473 U.S. 932; *Thornburgh v. American College of Obstetricians*, 476 U.S. 747, motion to allow counsel for the unborn denied 473 U.S. 931; *Hartigan v. Zbaraz*, 484 U.S. 171, motion to allow counsel for the unborn denied 479 U.S. 1003; *Webster v. Reproductive Health Services*, 492 U.S. 490, motion to allow counsel for the unborn denied 489 U.S. 106; *Ohio v. Akron Center for Reproductive Health*, 497 U.S. 502, motion to allow counsel for the unborn denied 493 U.S. 802; *Hodgson v. Minnesota*, 497 U.S. 417,

The unborn have a constitutional right to be represented by counsel to defend their right to life under the U.S. Constitution.[3] Judges who willfully deny this right are guilty of crime.[4] This denial makes *Roe v. Wade* void.

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motion to allow counsel for the unborn denied 492 U.S. 803; *New York v. Sullivan*, 500 U.S. 173, motion to allow counsel for the unborn denied 497 U.S. 1002; *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 120 L Ed 2d 674, motion to allow counsel for the unborn denied 117 L Ed 2d 614; *National Organization for Women v. Scheidler*, 126 L Ed 2d 99, motion to allow counsel for the unborn denied 125 L Ed 2d 786 (1993); *Schenck v. Pro-Choice Network of Western New York*, (No. 95-1065), __ L Ed 2d __ (1996), motion to allow counsel to represent the unborn denied __ L Ed 2d __ (1995); *Hill v. Colorado*, No. 98-1856, motion to allow counsel to represent unborn denied __ L Ed 2d (1999).

[3] Even in civil proceedings, where crucial deprivations are threatened, such as loss of welfare, due process guarantees (1) prior notice of the factual and legal bases; (2) the right to be represented by counsel; (3) the right to confront and cross-examine adverse evidence; and (4) the right to present evidence. *Goldberg v. Kelly*, 397 U.S. 254, 268-271 (1970); *In Re Gault*, 387 U.S. 1 (1967).

Will the Court claim that procedures, which could not be used to deprive a mother of welfare, could be used to exclude her from the protection of the U.S. Constitution so that she could be killed with impunity from criminal laws? This is preposterous.

The Constitution would not permit any court to condemn even one single Jew to death in a criminal case, but deny any of these procedural rights. Then neither can it permit any court to condemn all Jews in the United States to death, but deny any of these procedural rights, by calling it a civil proceeding, and decreeing the lives of all Jews are not protected by the U.S. Constitution, and it is "liberty" to kill all Jews with impunity from criminal laws.

Everyone is entitled to all these procedural protections before any court can decree that their life is not protected by the Constitution, and they can be killed with impunity from criminal statutes.

[4] "Even judges ... could be punished criminally for willful deprivations of constitutional rights." *Imbler v. Pachtman*, 424 U.S. 409 (1976).

B. The Court Effected Its *Roe v. Wade* Killings By Unconstitutionally Refusing To Allow Any Prior Notice Of The Standards, The Burdens Of Proof, Or The Evidence Which It Used To Infer That The Lives Of The Unborn Are Not Protected By The Constitution.

The U.S. District Court in *Roe v. Wade* did not even look to see if the lives of the unborn were protected by the U.S. Constitution. This question was argued for the first time after the case reached the U.S. Supreme Court. Since the Court had never previously excluded anyone from the protection of the U.S. Constitution so they could be killed with impunity from criminal statutes, the parties had no prior notice of the factual and legal bases for such an exclusion.

In the aftermath of *Dred Scott* and the Civil War, the Fourteenth Amendment was intended to assure the people that the Court could never again convulse the nation by implying another exception to the Constitution's universal guarantee of life and liberty to "any person."[5]

But in 1973, the Court not only defied this long-standing legitimate public expectation and implied another exception to the words "any person," but it also gave the parties no prior notice of the factual and legal basis of its decision.

In particular, the Court gave the parties in *Roe v. Wade* no prior notice of the constitutional standards, the burdens of proof, or the evidence, which the Court used to imply that the Fourteenth Amendment's express guarantee of life to "any person" did not include the unborn.

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[5] The history of how *Dred Scott v. Sanford*, 19 How. 393 (1857), triggered the Civil War is outlined in the *amicus curiae* brief filed herein by Legal Defense for Unborn Children at 4-6. *See also* Ernest, *supra* note 1, at 20-29.

In *Dred Scott,* the Court ruled that the words "any person" in the Fifth Amendment did not include black persons, and they could not sue in the Courts of the United States to see if they were free or slave.

The first time the parties had notice was when *Roe v. Wade* was published, and the victims were already condemned to death. An original party objected that it lacked the prior notice needed to defend the unborn:

> (N)ot only did the Court set a new constitutional standard, but at the same moment the Court applied the standard **without giving the Appellees notice** or opportunity to present evidence with respect to the point in gestation at which such standards, if they be correct as a matter of law in the first place, should be applied. "Viability", "meaningful life" or existence, "fetal life": all presumably have medical meaning which should be subject to medical testimony before a decision of constitutional import becomes solidified in concrete. These concepts are not even necessarily the appropriate ones.[6]

But the Court refused to allow the original parties to have any prior notice. Thus the Court commenced its killings.

And the Court has maintained its killings despite repeated objections that the unborn had no prior notice in *Roe v. Wade* of the factual and legal bases needed to defend the unborn's right to life under the U.S. Constitution.[7]

The unborn have a constitutional right to prior notice of all the factual and legal bases before they can be excluded from the protection of the Constitution so they can be killed with impunity from criminal statutes.[8] Judges who willfully deny this right are guilty of crime.[9] This denial makes *Roe v. Wade* void.

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[6] Petition for Rehearing 6, *Doe v. Bolton*, 410 U.S. 179 (1973), denied 410 U.S. 959 (1973). (emphasis added)

[7] *See* cases in note 2, *supra.*

[8] *See* note 3, *supra.*

[9] *See* note 4, *supra.*

C. The Court Effected Its *Roe v. Wade* Killings By Using Unconstitutional Secret Proceedings To Find Evidence To Infer That The Lives Of The Unborn Are Not Protected By The Constitution.

In *Roe v. Wade*, the Court used secret evidentiary proceedings to find evidence to imply that the Constitution's express guarantee of life to "any person" did not include the unborn. The Court conducted these secret proceedings in its back rooms. The parties were not allowed to be present. No public record was made of these secret proceedings.

The purpose of these secret proceedings was to give the Justices an opportunity to find evidence to conclude that the Constitution's guarantee of life to "any person," an express guarantee in absolute terms, did not mean what it plainly said, and to somehow imply that the unborn were excluded.

An original party objected to these secret proceedings:

> "The Court has taken judicial notice of innumerable facts and factors, some which are expressly referred to in the Court's decision and some which are **unknown to the parties** but which apparently were **extricated from various sources by the Court's diligent research,** which facts nevertheless should be subject to refutation and counter-evidence since they form the foundation for the Court's opinion...of constitutional stages of fetal growth." Petition for Rehearing 4, *Doe v. Bolton*, 410 U.S. 179 (1973), denied 410 U.S. 959 (1973). [emphasis added]

The first time the victims saw the evidence used against them was after *Roe v. Wade* was promulgated and they were already condemned to death. But the Court overruled the party's objection to its secret evidentiary proceedings. Thus the Court commenced its killings.

And the Court has maintained its killings despite repeated objections that it used secret proceedings in *Roe v. Wade*.[10]

[10] *See* cases in note 2, *supra*.

The unborn have a constitutional right not to be excluded from the protection of the U.S. Constitution by secret evidentiary proceedings.[11] Judges who willfully deny this right are guilty of crime.[12] This denial makes *Roe v. Wade* void.

D. The Court Effected And Maintains Its *Roe v. Wade* Killings By Unconstitutionally Refusing To Allow Its False Evidence, Which It Used To Infer That The Lives Of The Unborn Are Not Protected By The Constitution, To Be Confronted And Cross-Examined.

Since the Court used secret evidentiary proceedings, the original parties had not seen all the evidence which the Court used to imply that the lives of the unborn are not protected by the U.S. Constitution. An original party asked permission to cross-examine the evidence which the Court used to imply that the lives of the unborn were not protected by the U.S. Constitution:

> The Court has taken judicial notice of innumerable facts and factors, some which are expressly referred to in the Court's decision and some which are unknown to the parties but which apparently were extricated from various sources by the Court's diligent research, **which facts nevertheless should be subject to refutation and counter-evidence** since they form the foundation of the Court's opinion...of constitutional stages of fetal growth.[13]

But the Court refused to allow its evidence in *Roe v. Wade*, which it used to imply that the lives of the unborn

[11] *See* note 3, *supra*.

[12] *See* note 4, *supra*.

[13] Petition for Rehearing 4, *Doe v. Bolton*, 410 U.S. 179 (1973), denied 410 U.S. 959 (1973). (emphasis added).

were not protected by the U.S. Constitution, to be cross-examined. Thus the Court commenced its killings.

And despite repeated objections that the Court fabricated false evidence in *Roe v. Wade* in order to imply that the Constitution's express guarantee of life to "any person" did not include the unborn, the Court has maintained its killings by steadfastly refusing to allow its evidence to be confronted and cross-examined.[14]

The unborn have a constitutional right to confront and cross-examine the evidence which the Court used to imply that their lives are not protected by the U.S. Constitution.[15] Judges who willfully deny this right are guilty of crime.[16] This denial makes *Roe v. Wade* void.

E. The Court Effected And Maintains Its *Roe v. Wade* Killings By Unconstitutionally Refusing To Allow Evidence To Be Presented On Behalf Of The Unborn To Prove That The Constitution's Guarantee Of Life To "Any Person" Does Include The Unborn.

In *Roe v. Wade*, the Court invented new constitutional standards on the protection of life which the parties did not see until after *Roe v. Wade* was decided. The parties never had opportunity to present evidence under these new standards.

An original party requested "an opportunity to present evidence" under the new constitutional standards, which it had not seen before, to show that the lives of the unborn are protected by the Constitution.[17]

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[14] *See* cases in note 2, *supra*.

[15] *See* note 3, *supra*.

[16] *See* note 4, *supra*.

[17] Petition for Rehearing at 3 - 6, 8, *Doe v. Bolton*, 410 U.S. 179 (1973), denied 410 U.S. 959 (1973) [emphasis added]. The party said:

> We are dealing here with a procedure long considered outlawed and which has suddenly become legal.
>
> ....
>
> The Court has selected a point in time at which states may protect fetal life, without any record of facts upon which to base the conclusion that only at "viability," as that term is defined by the Court, do the people of a state have authority to demand caution before a prenatal infant is destroyed.
>
> ....
>
> Appellees have had **no opportunity to show by evidence** in a traditional judicial trial setting at what gestational stage the separate life of the fetus is "meaningful" medically; in addition, the Court overlooked the significance of Georgia's legal recognition of meaningful human life as found in case law and statute.
>
> ....
>
> With **no opportunity** for Appellees to demonstrate the factual basis, in terms of current medical science, that its interest attaches at a particular point in the natural development of a human fetus, the Court has seized upon the convenient point of "viability" and crystallized constitutional command which bars State action.
>
> ....
>
> In the medical concept of "life," with its current body of technological knowledge, including such advances as fetal electro-cardiography and fetal electroencephalography, legal "life" should not be cemented at an event in a judicial conclusion which does not have the benefit of medical evidence.
>
> ....
>
> At any rate, Appellees **should have an opportunity to present evidence** and testimony to support the State's claim of medically and scientifically sound interest in requiring a cautious approach to the extinguishment of fetal life.

But the Court refused to allow the party to present evidence to show that the lives of the unborn were protected by the U.S. Constitution. Thus the Court commenced its killings.

And the Court has maintained its killings by steadfastly refusing to allow evidence to be presented on behalf of the unborn to prove that their lives are protected by the U.S. Constitution.[18]

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[18] *See* cases in note 2, *supra*.

The unborn have a constitutional right to present evidence in this case to prove that their lives are protected by the U.S. Constitution.[19] Judges who willfully deny this right are guilty of crime.[20] This denial makes *Roe v. Wade* void.

CONCLUSION ON JUDICIAL PROCEDURES

The Nuremberg Tribunal cited these judicial procedures as part of its evidence to convict Nazi judges of complicity in extermination and murder:

> In many instances they [the accused] were denied the right to introduce evidence, to be confronted by witnesses against them.... They were...denied the right of counsel of their own choice.... (T)he accused learned only a few moments before trial of the nature of the alleged crime for which he was to be tried. The entire proceedings from beginning to end were secret and no public record was allowed to be made of them.[21]

The Nuremberg Tribunal said, "Such a mock trial is not a judicial proceeding but a murder."[22]

The Court used procedures to effect and maintain its *Roe v. Wade* killings which were not judicial proceedings but murders.

And the Court claims it can use such mock trials to decree the extermination of Jews, or anyone else, to be liberty.[23]

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[19] *See* note 3, *supra*.

[20] *See* note 4, *supra*.

[21] *United States v. Altstoetter* [The Justice Case], 3 Trials of War Criminals Before the Nuernberg Military Tribunals 1046-47 (1951).

[22] *Id.*, at 1164.

[23] *See* pages 11-20, *infra;* Ernest, *supra* note 1, at 59-67.

II.
COUNSEL FOR THE UNBORN RAISES ISSUES, NOT RAISED BY THE PARTIES, WHICH DISPOSE OF ALL ISSUES IN THIS CASE.

A. The U.S. Constitution's Guarantee Of Life To "Any Person" Does Include The Unborn.

Counsel will prove that the Constitution's universal guarantee of life to "any person" does include the unborn.[24]

B. The U.S. Supreme Court And Leaders Of The U.S. Government Maintain The *Roe v. Wade* Killings By Conspiring to Impose The Nazi Doctrines On The United States Which The United States Itself Prosecuted As Extermination And Murder At Nuremberg.

By merely changing the names of the victims being killed, the U.S. Supreme Court has duplicated the crimes of "the supreme judge" of Nazi Germany.

At Nuremberg, the Nazi judges claimed they could not be found guilty of complicity in extermination and murder of millions of Jews and other minorities because "the supreme judge" of Nazi Germany had decreed those killings to be legal, and they were required to obey the decrees of "the supreme judge."[25]

Yet the United States prosecuted the Nazi judges and other justice officials for obeying the decrees of their supreme judge. And the Nuremberg Tribunal convicted them with the comment: "The dagger of the assassin was concealed beneath the robe of the jurist."[26]

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[24] *Amicus Curiae* Brief by Legal Defense for Unborn Children at 1-6, filed herein and incorporated by reference. *See also* Ernest, *supra* note 1, at 20-29.

[25] *United State v. Altstoetter*, *supra*, at 983-985, 1011, 1014.

[26] *United States v. Altstoetter*, *supra*, at 985.

The record proves that the U.S. Supreme Court conspires to impose those same Nazi doctrines on America. The Court decreed killings to be "liberty" which the people had defined by their homicide statutes to be "murder."[27] The Court decreed mass murder to be legal, just as "the supreme judge" of Nazi Germany decreed mass murder to be legal. By merely changing the names of the victims, the Court has duplicated the decree of "the supreme judge" of Nazi Germany.

2.

The U.S. Supreme Court was accused in U.S. District Courts of extermination and mass murder on the grounds that Justices cannot lawfully decree extermination or murder to be legal. The U.S. Government defended its Justices by claiming that its Supreme Court must be obeyed "no matter how misguided" its decrees may appear to be. The U.S. Government expressly argued in open court that its Supreme Court must be obeyed even if it decrees the mass murder of Jews, or anyone else, to be liberty. An incredulous U.S. District Judge asked the U.S. Government:

> **[U.S. District Judge]: Let me ask you to respond to this question. The plaintiff argues in his brief that the Supreme Court in *Roe v. Wade* took a discrete group of entities and said that these entities have no right to live, and thus may be killed.... And he said if you take *Roe v. Wade* and remove the word "fetus" and just substitute most any other word you want of another discrete group, that we wouldn't be here discussing this at all. Let's say that instead of "fetus," they said "Jews." That is the one he used in his brief.**
>
> **Would you argue stare decisis to me if, under *Roe v. Wade*, at the whim of neighbors Jews could be put to death?**
>
> **[U.S. Government Lawyer]: (I) would have to agree with the doctrine of stare decisis and advance it to the court.[28]**

Thus, while children were being killed in defiance of murder statutes, the U.S. Government defended its Justices accused of mass murder by claiming the same Nazi doctrines which the United States itself prosecuted as complicity in extermination and murder at Nuremberg.

It was undisputed that the U.S. Supreme Court decreed killings to be "liberty" which legislatures had defined to be "murder." It was undisputed that the victims were being killed in defiance of murder statutes. Yet the U.S. Government expressly claimed in open court that its Supreme Court must be obeyed even if it decreed the mass murder of Jews, or anyone else, to be liberty.

Although the U.S. District Judge objected that *Roe v. Wade* was "the worst decision by the Supreme Court in the history of the Court," he adopted the U.S. Government's arguments that he must obey the U.S. Supreme Court no matter whom it decreed a liberty to kill.[29]

3.

The petition for review of that decision filed in the U.S. Supreme Court accused it of mass murder:

> For the **67th time**, the U.S. Supreme Court is accused in its own court with mass murder in violation of State

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[27] *Amicus Curiae* Brief By Legal Defense for Unborn Children, *supra* note 24, at 7-16. *See also* Ernest, *supra* note 1, at 29-37.

[28] *Ernest v. United States Attorney for the Eastern District of Virginia and U.S. Attorney General*, U.S. District Court in Richmond, Civ. No. 84-0858, transcript of proceedings at 21-22, cert. denied 475 U.S. 1084 (1986).

[29] Petition for Cert. at A1, *Ernest v. United States Attorney for the Eastern District of Virginia and U.S. Attorney General*, cert. denied without comment, 475 U.S. 1084 (1986).

and federal statutes.[30]

The U.S. Government waived its right to oppose the petition for review, and thus the U.S. Supreme Court was accused in its own Court of extermination and mass murder, and the accusations were unopposed. Yet the Court neither denied that it had decreed mass murder to be liberty, nor objected to the U.S. District Court's ruling that it must obey the U.S. Supreme Court even if it decreed the mass murder of Jews, or anyone else, to be liberty.

If any Justice had believed that the U.S. Supreme Court did not have the power to decree the mass murder of Jews or anyone else to be liberty, the Justice would certainly have noted his or her objection. But no such objection was noted.

This record proves a conspiracy by the executive and judicial departments of the government of the United States to impose the Nazi doctrines on the United States which the United States itself prosecuted as complicity in extermination and murder at Nuremberg. Only the names of the victims being killed have been changed.

4.

Moreover, each Justice of the U.S. Supreme Court was named as a defendant in a civil suit, and accused in a State court of extermination and mass murder on the grounds that Justices cannot lawfully decree extermination or murder to be liberty.[31] The State court was asked to "Declare that there was probable cause to believe that the U.S. Supreme Court had conspired to commit murder" in violation of the State murder law.[32] Such a ruling could have been tantamount to

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[30] *Id.*, at page 50. (emphasis in text)

[31] *Ernest v. Rehnquist, Stevens, Breyer, O'Connor, Scalia, Kennedy, Souter, Thomas, Ginsburg, etc.; U.S. Attorney, etc.; U.S. Attorney General*, et al, in the Circuit Court of Fairfax, Virginia, Civil No. 90367.

[32] Complaint, *supra* note 31, at page 44.

the start of the criminal prosecution process against the Justices for extermination and mass murder.

History had never seen a moment when it was more imperative to meet the charges, and if possible, refute them. The charges were made in court, the place designated by law to hear such charges. The courthouse is the place where anyone, including the most powerful, can be summoned, confronted with the facts, and required to adequately explain, or face the consequences.

But the Justices did not deny that they had decreed killings to be "liberty" which that State had defined to be "murder." Nor did the Justices deny that under *Roe v. Wade*, victims were being killed in defiance of the State's murder statute. Nor did the Justices deny that they had been repeatedly accused of extermination and murder in the U.S. Supreme Court, but they had never attempted to refute the charges. Nor did the Justices deny that they were seeking to impose the Nazi doctrines on the United States which the United States itself prosecuted as extermination and murder at Nuremberg. To the contrary, this would be their defense.

The U.S. Government removed the case to the U.S. District Court in Alexandria.[33] Even though accused of extermination and mass murder, the Justices did not attempt to show one single allegation in the complaint to be wrong in fact or law. The record shows the charges to be true.

Rather each Justice, through his or her U.S. Government lawyer, claimed that all lower courts must obey the U.S. Supreme Court even if it decreed mass murder to be liberty.[34]

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[33] *Ernest v. Rehnquist, Stevens, Breyer, O'Connor, Scalia, Kennedy, Souter, Thomas, Ginsburg, etc.; U.S. Attorney, etc.; U.S. Attorney General*, in the U.S. District Court in Alexandria, Civil No. 89-732-A.

[34] The Justices claimed that the District Court "is prohibited by stare decisis from granting the relief requested in this action." Although a trial court was asked to find probable cause that the Justices had conspired to commit mass murder, the Justices defended themselves by claiming "a precedent of the [U.S. Supreme] Court must be followed by the lower

And the Justices also claimed that after the U.S. Supreme Court had decreed mass murder to be liberty, the victims being killed in defiance of murder statutes could not challenge the validity of its decree in any court.[35] The U.S. District Judge adopted the Justices' claims as law by summary decree - refusing to hold any hearings, and without showing any of the allegations in the complaint to be wrong in fact or law.

Thus, in defending themselves against accusations of extermination and mass murder, each Justice of the U.S. Supreme Court claimed the power to decree the mass murder of Jews, or anyone else, to be liberty. And this claim is now accepted by the government of the United States - its courts, Congress and president - as the supreme law of the land. This has been the steadfast policy of the U.S. Government, asserted in court after court, for about a quarter-century.[36]

All the lower federal judges who have upheld *Roe v. Wade*, and thus this Court's claim of power to decree murder and extermination to be liberty (including the judges below - Wollman, Arnold, Magnuson and Kopf) are accused herein of complicity in extermination and mass murder.[37]

5.

President Bill Clinton has repeatedly rejected pleas to withdraw the U.S. Government's claim, made in numerous

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federal courts no matter how misguided the judges of those courts may think it to be." *Ernest v. Rehnquist*, *supra* note 33, Government's Memorandum in Support of Motion to Dismiss at 3.

[35] *Id.*, Government's Memorandum in Support of Motion to Dismiss at 4.

[36] Some of these cases are: U.S. District Court in Alexandria, Civ. No. 89-732; U.S. District Court in Salt Lake City, Civ. No. 85-0026; U.S. District Court in Richmond, Civ. No. 84-0858; U.S. District Court in Portland, Civ. No. 81-0272.

[37] *See* Ernest, supra n. 1, at 66 n. 31 for a partial list of federal judges accused of complicity in extermination and murder.

courts, that its Supreme Court has the power to decree the mass murder of Jews or anyone else to be legal. President Clinton was informed:

> The general rule is that mistake of law is no excuse for breaking the law. The narrow exception of reasonable reliance on an official judicial opinion, thereafter found to be a mistake of law, does not even apply in homicide cases.
>
> ....
>
> If the U.S. Government's claim [that its Supreme Court has the power to decree the mass murder of Jews or anyone to be liberty and such decrees must be obeyed as the supreme law of the land] turns out to be a mistake of law, and you refuse to repudiate it while victims are actually being killed in defiance of murder statutes, then your acquiescence can implicate you in a national scheme of mass murder. This letter becomes a part of the record of this case as evidence of what you knew, and when you knew it.[38]

Although publicly accused of complicity in mass murder, and children were being killed in defiance of murder statutes, President Clinton repeatedly rejected requests to withdraw the U.S. Government's claims, and he supported the *Roe v. Wade* killings on numerous occasions.[39]

Thus this president has contributed to this giant conspiracy to kill victims in defiance of murder statutes, and to impose the Nazi doctrines on the United States which the United States itself prosecuted as extermination and murder at Nuremberg. A jury could find that this amounts to complicity in extermination and murder.

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[38] Letter to President Clinton dated March 31, 1993, certified no. P 867-382-498, received by the White House April 9, 1993.

[39] Ernest, *supra* note 1, at 74-81.

6.

Leaders of the U.S. Congress have also aided this conspiracy.[40] Congress has the constitutional duty to control the federal judiciary. But, as federal courts conspired to decree mass murder to be liberty, to kill children in defiance of murder statutes, and to impose Nazi doctrines on the United States, Congress defied its legal duty to control the federal judiciary.

Leaders of Congress, by acts of commission or omission, helped to maintain the *Roe v. Wade* killings.[41] But for these acts of commission or omission by members of Congress, Nazi doctrines could not have been imposed on America, and the killings could not have proceeded.

Since children are being killed in defiance of murder statutes and others criminal laws, because leaders of Congress refuse to do their constitutional and statutory duty to control the federal judiciary, a jury could find that those leaders of Congress are guilty of complicity in extermination and murder.

7.

A U.S. courthouse has become a place where officials con-

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[40] The Complaint, *supra* n. 33, at p. 3, alleged that various members of the committees on the Judiciary, whose particular duty was to control the courts, were a part of the conspiracy: "The co-conspirators include ex-Chairman Peter Rodino, Chairman Rep. Jack Brooks, sub-committee chairman Rep. Don Edwards, sub-committee chairman Rep. Robert Kastenmeier; Chairman Sen. Joseph Biden, ex-Chairman Sen. Edward Kennedy. A jury could find this conspiracy to be murder." *See also* Ernest, *supra* note 1, at 82-103.

[41] When the U.S. Congress held hearings on *Roe v. Wade*, it conspired to allow all the false evidence in *Roe v. Wade* to be presented, but refused to allow the rebuttal to be presented. Thus Congress conspired to present false evidence to the nation as if it were the truth. And many leaders of Congress have publicly endorsed the *Roe v. Wade* killings. *See also* Ernest, *supra note* 1, at 82-103.

spire to commit extermination and murder, fabricate false evidence to make their killings appear legal, and then maintain their killings decade after decade by conspiring to overthrow the U.S. Constitution.

8.

The evidence shows that leaders of the judicial, executive and legislative branches of the government of the United States conspire:

1. to claim the power to decree the extermination and murder of Jews, or anyone else, to be legal;
2. to actually kill victims in violation of murder statutes; and
3. to maintain their killings by supplanting the U.S. Constitution as the supreme law of the land and imposing the Nazi doctrines on the United States which the United States itself prosecuted as extermination and murder at Nuremberg.

The human mind cannot imagine a plainer or bolder case of U.S. Officials committing treason to the U.S. Constitution.

In 1858 an unknown lawyer named Abraham Lincoln accused the U.S. Supreme Court, two U.S. Presidents, and leaders of the U.S. Congress of conspiring to overthrow the U.S. Constitution and to impose a slave empire on America.

In 1998 a book reviewed the evidence presented in this application, and asked:

> Has the U.S. Supreme Court committed mass murder?
> Have four U.S. Presidents committed mass murder?
> Have leaders of the U.S. Congress committed mass murder?[42]

These questions are now before the public, and counsel submits that the search for truth will surely continue until these questions are correctly answered.

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[42] Ernest, *supra* note 1, at 10.

CONCLUSION

The Court is moved to allow counsel to represent the unborn and defend their right to life under the U.S. Constitution, and to prove that the Constitution's guarantee of life to "any person," as used in the Fifth and Fourteenth Amendments, does include the unborn. Both the State and federal governments have a duty to protect unborn life.

Alan Ernest
Counsel

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No. 99-830

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1999

DONALD STENBERG, ATTORNEY GENERAL FOR THE STATE OF NEBRASKA, ET AL, PETITIONERS

v.

LEROY CARHART, RESPONDENT

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE WITH BRIEF BY LEGAL DEFENSE FOR UNBORN CHILDREN IN SUPPORT OF THE PETITIONERS

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MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF

Interest of *Amicus Curiae*

The *amicus curiae* supports the upholding of the Nebraska abortion statute.

The *amicus curiae* brief defends the constitutional right to life of the unborn which the parties have not done.

Argument

The *amicus curiae* proves that the U.S. Constitution's universal guarantee of life to "any person," made in its Fifth and Fourteenth Amendments, does include the unborn. Thus the Court must not only overrule *Roe v. Wade*, 410 US. 113 (1973), it must rule that State and federal governments have a duty to protect unborn life.

This disposes of all issues in this case.

Consent to File

Neither petitioners nor respondent gave written consent to file this *amicus curiae* brief.

Conclusion

The U.S. Constitution's universal guarantee of life to "any person" is America's most important legal right. The lives of tens of millions of children depend on their being permitted to present all relevant evidence and arguments to prove that the U.S. Constitution's universal guarantee of life to "any person" does include the unborn.

Alan Ernest
Counsel

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BRIEF FOR THE LEGAL DEFENSE FOR UNBORN CHILDREN AS AMICUS CURIAE IN SUPPORT OF THE PETITIONERS

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INTEREST OF *AMICUS CURIAE*

The *amicus* defends the right to life of the unborn.

SUMMARY OF ARGUMENT

The Constitution's guarantee of life to "any person," made in its Fourteenth Amendment, does include the unborn.[1]

ARGUMENT

I.

THE U.S. CONSTITUTION'S GUARANTEE OF LIFE TO "ANY PERSON" DOES INCLUDE THE UNBORN.

The Declaration of Independence announced that reverence for life is America's founding principle. It said that all men are created equal, all are endowed by their Creator with an unalienable right to life, and the purpose of government is to protect the life of everyone.

America's faith is that if we will follow our reverence for life wherever it may lead, then a future of more abundant life, which we can all look forward to with hope, will unfold before us.

On the other hand, in *The Federalist* No. 10, James Madison warned that the primitive idea that some can gain by harming others had ruined all democracies known to history. And today, the lethal inventions of science have made reverence for life the only way to the future.

A. On Its Face, The Constitution's Guarantee Of Life To "Any Person" Does Include The Unborn.

This guarantee of life to everyone was incorporated into the U.S. Constitution. The 14th Amendment's guarantee of life reads: "(N)or shall any State deprive ***any person*** of life...

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[1] *See also* Alan Ernest, *Mass Murder Is Liberty: How The United States Is Ruled By The Decree MASS MURDER IS LIBERTY* 20-73 (1998).

Rule 37.6 disclosure: Counsel authored the whole *amicus curiae* brief; no monetary contributors are required to be identified.

without due process of law." (emphasis added)

The words "any person" are universal, admit of no exceptions for anyone, make no distinction between born and unborn life, and on their face include the unborn, the same as everyone else. The obvious purpose of guaranteeing life universally to "any person" was to prohibit officials making exceptions so some persons could be exterminated.

The Court admitted that if the word "person" included the unborn, then *Roe v. Wade* "collapses," because the lives of the unborn would be "guaranteed" by the Constitution.[2] But the Court implied that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn."[3] Thus the Court hit the Constitution head-on, directly defied its express prohibition of extermination, and condemned to death those victims whom the Constitution, by its plain words, endeavors to preserve.

The words "any person" are the two most important words ever written into law because they protect the lives of everybody from extermination, and they summarize America's unique contribution to civilization. As Abraham Lincoln said, what made America great was the promise "that *all* should have an equal chance."[4]

The words "any person" are the words which guarantee that equal chance to live to *all*. They stand as the supreme political achievement of the human race, the prize of millenniums of struggle. If the Constitution had stated it protected the life of "any person - except the unborn," then its words would support *Roe v. Wade*. But its words say "any person," without any exceptions.

The Court ruled that the words "any person" included Chinese aliens, merely saying the words are "universal in their application, to all persons…without regard to any differences." *Yick Wo v. Hopkins*, 118 U.S. 356, 369 (1886).

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[2] *Roe v. Wade*, 410 U.S. 113, 156-157 (1973).

[3] *Id.*, at 158.

[4] Abraham Lincoln, 4 *The Collected Works of Abraham Lincoln* 240 (R. Basler ed. 1953). (emphasis in text)

In 1975, the Federal Constitutional Court of West Germany held that the words in its Constitution, "Everybody has the right to life," did include the unborn. The court explained that the word "everybody" is universal.[5]

But in *Roe v. Wade*, the Court ignored the letter of the law. Instead the Court focused on the isolated word "person," and ignored its modifier "any." Yet "any" is the word which means "all," and extends the right to life to everyone without any exceptions.

By reading the universal guarantee of life to "any person" as if it were merely a guarantee to "some persons," the Court did the most forbidden thing and reduced the most important law in history to nothing.

The Constitution extends its guarantee of life to "any person." The letter of the law permits no exceptions. On their face the universal words "any person" do include the unborn.

B. The Spirit Of The Law Proves That The Constitution's Guarantee Of Life To "Any Person" Does Include The Unborn.

Roe v. Wade violates the spirit of the law, as well as its letter. The Court itself ruled that the Declaration of Independence is the spirit of the Fourteenth Amendment.[6]

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[5] "No distinction can be made among the several stages of developing life before birth, or between prenatal or postnatal life." The court's opinion is reported in R. Destro, *Abortion and the Constitution: The Need For A Life Protective Amendment*, 63 Cal. L. Rev. at 1341-51 (1975).

[6] *Gulf, Colo. & S. Ry v. Ellis*, 165 U.S. at 159-160 (1896):

> "The first official action of this nation declared the foundation of government in these words: "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life…." While such declaration of principles may not have the force of organic law…yet the latter is but the body and the letter of which the former is the thought and the spirit, and it is always safe to read the letter of the Constitution in the spirit of the Declaration of Independence. No duty

There is no real medical dispute that the unborn have been created and are alive.[7] Reading the letter of the Constitution, its guarantee of life to "any person," in the spirit that ***all*** are "created equal," and ***all*** shall get their chance to live, proves that the words "any person" do include the unborn.

C. History Confirms That The Constitution's Guarantee Of Life To "Any Person" Does Include The Unborn.

In addition to the letter and spirit of the law, the universal embrace of this guarantee of life to "any person" is also evident from its history.

The last time the Court implied an exception to the words "any person" was *Dred Scott v. Sandford,* 19 How. 393 (1857). There the Court ruled that the phrase in the Declaration of Independence, "all men are created equal," did not include black persons; the words "any person," as used in the Fifth Amendment, did not include black persons; there was a constitutional right to own a slave ("the right of property in a slave is distinctly and expressly affirmed in the Constitution"); Congress could not prohibit slavery in the territories; people were free to choose whether or not to own slaves; and black persons could not sue in federal courts to see if they were slave or free.

Abraham Lincoln opposed *Dred Scott*. If officials can say all men are created equal except black men, he asked "where will it stop?" If officials can say the Declaration does not include black persons, Lincoln argued that they can say it does not include any other person. He claimed that *Dred Scott* was based on "falsehood."[8] He alleged a conspiracy by the U.S. Supreme Court, two U.S. Presidents, and leading members of

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rests more imperatively upon the courts than...to secure the equality of rights which is the foundation of free government."

[7] The uncontested medical evidence in the Texas brief in *Roe v. Wade* showed the fetal heart begins "pulsations at 24 days," and "brain waves have been noted at 43 days," and the unborn child is "alive."

[8] A. Lincoln, *2 The Collected Works of Abraham Lincoln* 495 (1953).

Congress to overturn the U.S. Constitution and to impose a slave empire on America.[9]

Lincoln said he would not obey *Dred Scott*. Citing both Thomas Jefferson and Andrew Jackson as authority,[10] he said the president swears an oath to obey the Constitution as he understands it, and not as it was understood by the Supreme Court. If the president were bound by *Dred Scott*, Lincoln explained in his Inaugural Address, "the people will have ceased, to be their own rulers...."[11]

Dred Scott triggered a civil war. Various States withdrew from the Union rather than be deprived of their constitutional right to own a slave, as decreed by the Court. President Lincoln defied the Court's *Dred Scott* decision that there was a constitutional right to own a slave because he emancipated the slaves and declared them to be "forever free."[12] He reminded us at Gettysburg that we were fighting to see whether a nation dedicated to the proposition that "all men are created equal" could long endure.

The framers intended the 14th Amendment to rededicate America to its original proposition. One of its framers said:

> It establishes equality before the law, and it gives to the humblest...the most despised...the same protection before the law as it gives to the most powerful....Without

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[9] *Id.*, at 461-469, 521.

[10] *Id.*, at 402, 516-17.

[11] A. Lincoln, 4 *The Collected Works of Abraham Lincoln* 268 (1953).

[12] A. Lincoln, 6 *The Collected Works of Abraham Lincoln* 28-30 (1953). All constitutional rights suspended during wartime are automatically reinstated after the war is over. If Lincoln had believed that the president was bound by the Court's decision in *Dred Scott*, that there was a constitutional right to own a slave, he could only have freed slaves for the war's duration - not forever. But Lincoln rejected the Court's claim that there was a constitutional right to own a slave, and he proclaimed the slaves to be "forever free."

this…there is no republican government.[13]

The framers of the Fourteenth Amendment learned from *Dred Scott*. They said the Supreme Court must never again imply exceptions to the words "any person." They employed the universal words most suited for this purpose.

And by the middle of the 19th century, medical science had proved that an unborn child was alive throughout gestation, and there was no time during gestation when science could draw a line and say the unborn were not alive. By the time the Fourteenth Amendment was adopted in 1868, the vast majority of States had already enacted criminal abortion laws to protect all stages of unborn life, and within a few years such laws were universal.

The history of these criminal abortion laws shows that the framers and adopters of the Fourteenth Amendment intended its universal guarantee of life to "any person" to mean what it says, and to include the unborn the same as everyone else.

By merely changing the names of the victims, the Court repeats the *Dred Scott* disaster. The Court repudiates a major point of the Civil War and the Fourteenth Amendment: that judges would never again be at liberty, as in *Dred Scott*, to convulse society by implying more exceptions to the words "any person." The Court claims that without one word of explanation the framers intended their guarantee of life to "any person" to sweep away all their abortion statutes and make the killings, which they said were criminal, into "liberty." And the Court amends the Declaration of Independence to read "all men are created equal, except those created to be killed." And the Court claims it can decree who was created to be killed.

The Court did the most forbidden thing: it defied the U.S. Constitution's guarantee of life to "any person" and decreed extermination in violation of criminal statutes to be legal.

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[13] Rep. Jacob Howard, quoted in B. Schwartz, 1 *Statutory History of the United States: Civil Rights* 262 (1970).

The Fourteenth Amendment's letter, spirit and history prove that its universal guarantee of life to "any person" does include the unborn.

II.

ROE v. WADE IS VOID BECAUSE IT CRIMINALLY DEFIED THE CONSTITUTION'S GUARANTEE OF LIFE TO "ANY PERSON" AND CONDEMNED TO DEATH MILLIONS OF VICTIMS WHOM THE CONSTITUTION ENDEAVORS TO PRESERVE.

A.

Roe v. Wade Criminally Defied The Constitution's Guarantee Of Life To "Any Person" Because The Court Decreed Killings To Be "Liberty" Which The People Had Defined To Be "Murder." In Effect, The Court Decreed "Mass Murder Is Liberty."

When *Roe v. Wade* was decided in 1973, an abortion was murder if the child was "born alive." A child could be born alive during second or third trimester abortions. Indeed, the State of Georgia forewarned the Court that certain abortions were "murder."[14] But the Court scorned that warning and decreed those very killings to be "liberty."[15]

In 1976, a physician explained to Congress that *Roe v. Wade* permitted second trimester hysterotomy abortions and children killed by this abortion can be "born alive":

> With few exceptions, babies aborted by this will all move, will all breathe, and some will cry…. Almost all were **born alive**.[16] (emphasis added)

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[14] *Doe v. Bolton*, 410 U.S. 179 (1973), Brief for Appellees 52-53.

[15] *Roe v. Wade*, 410 U.S. 113, 153 (1973). The Court claimed that a right to abortion was included in the "concept of personal liberty."

[16] Testimony of Dr. J.C. Willke, M.D., and Barbara Willke, 1 *Hearings on Constitutional Amendments on Abortion*, Before subcomm. On Civil and Constitutional Rights, of the House Comm. Of the Judiciary, 94th Cong., 2d Sess., at 397 (1976).

The physician showed Congress this photograph of a child killed by a salt poisoning abortion:

If the Court canot lawfully decree murder to be liberty, about 3 million abortions can be investigated as murders

The physician testified that this method could also result in a child being "born still alive."

For almost four centuries Americans had defined such killings to be "murder." But in 1973 the Court decreed such killings to be "liberty."

The Court also decreed a constitutional right to third trimester abortions to preserve the mother's "health," in effect, abortion on demand right up to birth.[17] Of course, for

[17] *Doe v. Bolton*, 410 U.S. 179 (1973). With no precedent in law or medicine, the Court decreed that abortions could be performed in the 3rd trimester to protect the woman's "health," which the Court ruled included "all factors - physical, emotional, psychological, familial, and the woman's age - relevant to the well being of the patient." Few abortions could be prosecuted as criminal under this revolutionary test.

almost four centuries those killings (not necessary to save the mother's life) were murder if the child were "born alive."

And by 1973, States had commonly decided that in the third trimester a child need not be "born alive" but was a human being within their homicide or murder statutes if the child were killed "in the process of being born."[18] The Court also decreed those murders to be liberty. Indeed under *Roe v. Wade*, doctors kill children in the very process of being born.

But if the Court cannot lawfully decree these murders to be liberty, then we have the new reckoning. And, as the new millennium begins, about three million abortions can be investigated as murders.[19]

1. The Court Decreed Killings To Be "Liberty" Which Americans Had Defined To Be "Murder" Since Earliest Colonial Times.

America's first settlement at Jamestown followed the English common law, as did other colonies. The common law defined an abortion, in which a "quick" (about 4 months gestation) child died after being "born alive," to be "murder."[20] Even if not yet viable, if the child was "born alive," Coke (the standard 17th century legal authority) condemned the abortion as "so horrible an offense" and "this is murder."[21]

Today Coke's work is an indispensable dictionary for de-

[18] *People v. Chavez*, 77 Cal. App. 2d 621, 626 (1947). Such abortions are now commonly called "partial-birth abortions" where doctors kill children who are in the process of being born.

[19] About 10% of all abortions each year are 2nd or 3rd trimester abortions. The Washington Post, April 26, 1985, A11. Most 2nd and 3rd trimester abortion procedures can result in a child "born alive."

[20] Coke, 3 *Institutes* 50; Hawkins, 1 *Hawkins* Ch. 13, s. 16; Blackstone, 4 *Bl. Com.* 198.

[21] Coke, 3 *Institutes* 50.

fining the foundation of American liberty, such as distinguishing between liberty and murder.[22] (Today all Americans must rely on these same bedrock legal authorities, as set out for the unborn, to prevent their own extermination from being called liberty. If these authorities cannot protect the unborn, then they cannot protect any other group of persons.)

The English writers cited this as the correct statement of the law.[23] And English courts fo[illegible]ved this law.[24]

The common law was the la[illegible] of the land in colonial America. By allowing second and third trimester abortions, the Court decreed killings to be "liberty" which Americans had defined to be "murder" since earliest colonial times.

2. The Court Decreed Killings To Be "Liberty" Which The Framers And Adopters Of The Fourteenth Amendment Defined To Be "Murder."

The common law is the dictionary which American courts use to construe the State and federal homicide statutes.[25]

By the time the Fourteenth Amendment was adopted in 1868, American legal authorities and State supreme courts had long followed the common law rule that second and third trimester abortions were murder if the child were born alive. And viability was irrelevant. If death were caused by the child being too immature to survive outside the womb, the abortion

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[22] Jefferson wrote that Coke's *Institutes* were "the fundamental code of English law." "This work is executed with so much learning and judgment, that I do not recollect that a single position in it has ever been judicially denied.... It may still be considered as the fundamental code of English law." T. Jefferson, 14 *The Writings of Thomas Jefferson* 57 (1907). Jefferson served on the 1776 committee which adapted Virginia's laws to republican form, the common law being assigned to him.

[23] J. F. Archbold, 1 *Complete Treatise on Criminal Procedure, Pleading and Evidence* 783 (Waterman Am. ed. 7th ed. 1860); W.O. Russell, 1 *A Treatise on Crimes and Misdemeanors* 671-672 (4th ed. 1865).

[24] *Regina v. West,* 2 C & K 784 (1848).

[25] *Clarke v. State*, 117 Ala. 1 (1898); *Hamilton v. United States*, 26 App. D.C. 382 (1905).

was murder.

In 1859 the American Medical Association reported the law of murder which existed throughout the United States:

> If a person, intending to procure abortion, does an act which causes the child to be born earlier than its natural time, and therefore in a state much less capable of living, and it afterwards die in consequence of such premature exposure, the person who by this misconduct brings the child into the world, and puts it into a situation in which it cannot live, is guilty of ***murder***.[26] (emphasis added)

This was the uncontradicted view in the United States when the Fourteenth Amendment was adopted.[27] This definition of murder was approved by the preeminent legal writers of the 19th century,[28] and it was adopted by State supreme courts.[29] It was still the law in 1973.[30] In 1975 the New Jersey courts applied this law to an unviable fetus born alive:

> That a fetus may be the victim of murder if it be born alive has long been a part of our common law....Coke, *Institutes* 58 (1648).[31]

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[26] Reported in A. S. Taylor, *A Manual of Medical Jurisprudence* 462 (6th ed. 1866). He described the AMA's report as "a complete and comprehensive exhibit of laws of each of the United States." *Id.*, at 460.

[27] J. P. Bishop, 2 *Commentaries on the Criminal Law* 365 (4th ed. 1868); A. S. Taylor, *supra* note 26, at 462, 517 (1866).

[28] F. Wharton, *A Treatise on the Law of Homicide in the United States* 93 (1855); Bishop, *supra* note 27; Taylor, *supra* note 26.

[29] *Clarke v. State*, 117 Ala. 1 (1898); *Watson v. State*, 117 A 2d 549 (1955); *Porter v. Lassiter*, 87 S. E. 2d 100 (1955); *Bennett v. State*, 377 P 2d 634 (1963); *State v. Anderson*, 343 A 2d 505 (1975); *People v. Chavez* 176 P. 2d 92 (1947); *Singleton v. State*, 35 So 2d 375 (1948).

[30] 2 L. Burdick, *The Law of Crime* 156 (1946); 1 *Wharton's Criminal Law and Procedure* 434 (12th ed. 1957); R. Perkins, *Criminal Law* 30 (2d ed. 1969).

[31] *State v. Anderson*, 343 A. 2d 505, 508 (1975), *affirmed* 413 A. 2d 611 (1980). The court rejected the claim it was not murder because "the infants were never capable of maintaining a separate and independent existence." *Id.* at 615.

For almost four centuries governments came and went in America, but this law of murder endured as the law of the land - showing that some things are far deeper than mere governments and go to the very heart of how humans define themselves and what they reach to be. And this law is binding on the U.S. Supreme Court.[32]

In *Roe v. Wade* the Court ruled that States could not protect unborn life until the third trimester which the Court set at viability, "about 7 months."[33] But due to the Court's revolutionary definition of the mother's "health," the Court effectively allowed abortions even as the child was being born. Thus the Court decreed second and third trimester abortions to be "liberty" which the framers and adopters of the Fourteenth Amendment had defined to be "murder."

3. The U.S. Supreme Court And The U.S. Government Claim Power To Decree The Extermination Or Mass Murder Of Jews, Or Anyone Else, To Be Liberty.

Of course, if the U.S. Supreme Court can decree the mass murder of some persons to be liberty, it can decree the mass murder of anybody to be liberty.

Indeed, the U.S. Supreme Court was accused in U.S. District Courts of mass murder on the grounds that Justices cannot lawfully decree mass murder to be liberty. The U.S. Government defended its Supreme Court by expressly claiming the Court must be obeyed even if it decrees the mass murder of Jews, or anyone else, to be liberty. An incredulous U.S. District Judge asked the U.S. Government:

> **[U.S. District Judge]: Let me ask you to respond to this question. The plaintiff argues in his brief that the Supreme Court in *Roe v. Wade* took a discrete group of entities and said that these entities have no right to live, and thus may be killed.... And he said if you take *Roe v. Wade* and remove the word "fetus" and just substitute most any other word you want of another discrete group, that we wouldn't be here discussing this at all. Let's say that instead of "fetus," they said "Jews." That is the one he used in his brief.**
>
> **Would you argue stare decisis to me if, under *Roe v. Wade*, at the whim of neighbors Jews could be put to death?**
>
> **[U.S. Govt. Lawyer]: (I) would have to agree with the doctrine of stare decisis and advance it to the court.[34]**

As children were being killed in defiance of murder statutes, the U.S. District Judge adopted the U.S. Government's claim that he must obey the U.S. Supreme Court even if it decreed mass of murder Jews, or anyone else, to be liberty. And on review, not one single Justice had any objection.[35]

Moreover the Justices were individually accused in a U.S. District Court of mass murder on the grounds that they cannot lawfully decree mass murder to be liberty. Each Justice defended himself or herself by claiming that all lower courts must obey the U.S. Supreme Court "no matter how misguided" its decrees may appear to be.[36]

And in this case the State of Nebraska defined partial-birth

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[32] The Court must accept the construction given by a State to its own statute. *Pollard v. Dwight*, 4 Cranch 421, 429 (1808).

[33] *Roe v. Wade*, 410 U.S. at 160, 163.

[34] *Ernest v. U.S. Attorney for the Eastern District of Virginia and U.S. Attorney General*, U.S. District Court in Richmond, Civ. No. 84-0858, transcript 21-22. The complaint attacked the validity of *Roe v. Wade* on the grounds that Justices cannot lawfully decree mass murder to be liberty, and demanded that the District Judge refuse to obey *Roe v. Wade*.

[35] *Ernest v. U.S. Attorney for the Eastern District of Virginia, and U.S. Attorney General*, cert. denied 475 U.S. 1084 (1986).

[36] *Ernest v. Rehnquist, Stevens, Breyer, O'Connor, Scalia, Kennedy, Souter, Thomas, Ginsburg, etc., U.S. Attorney, etc., U.S. Attorney General*, U.S. District Court in Alexandria, Civil No. 89-732A, Defendants' Motion to Dismiss 3. The District Court adopted this argument as law by summary decree - refusing to even allow a hearing.

abortions, killing a child in the process of being born, to be a felony punishable by up to twenty years in a penitentiary. But the lower federal judges, claiming they must obey the Court's decree in *Roe v. Wade*, permitted the killings to continue.

Thus the U.S. Government and its U.S. Supreme Court officially claim the power to decree the extermination or mass murder of Jews, or anyone else, to be liberty.

4. The U.S. Supreme Court Has Committed Treason To The U.S. Constitution.

Chief Justice John Marshall would have called *Roe v. Wade* "treason to the Constitution." He wrote that the purpose of the Constitution was to control the government, including judges, and the intention of its framers is the law.[37] He later ruled that the Court could not extend the Constitution "to objects not…contemplated by its framers."[38] And the Chief Justice warned that if the Court usurped such power, it would be "treason to the Constitution."[39]

The officials to be controlled are not free to invent a constitution more to their liking. Lawless officials can overthrow a constitution as surely as armed rebels. Indeed President George Washington warned that "change by usurpation" might be convenient, but it was "the customary weapon by which free governments are destroyed."[40]

By defining killings to be "liberty" which the framers had defined to be "murder," the Court exactly extended the Constitution to objects not contemplated by its framers. The Court confronts the nation with the boldest and plainest case of officials committing "treason to the Constitution" which it could encounter.

By merely changing the names of the victims being killed, the U.S. Supreme Court has duplicated the decree of "the

[37] *Marbury v. Madison*, 1 *Cranch* at 176-180 (1803)
[38] *Ogden v. Saunders*, 12 Wheat. at 332 (1827).
[39] *Cohens v. Virginia*, 6 Wheat. at 404 (1821).
[40] G. Washington, 35 *The Writings of George Washington* 229 (1940).

supreme judge" of Nazi Germany. At Nuremberg the Nazi judges claimed they could not be prosecuted for complicity in extermination and murder because "the supreme judge" had decreed the killing of Jews and other minorities to be legal, and they were obligated to obey the decrees of their supreme judge.[41] But the United States prosecuted those Nazi judges and other justice officials for obeying their supreme judge.

Now U.S. Officials conspire to impose the same Nazi doctrines on the United States which the United States itself prosecuted as extermination and murder at Nuremberg: (1) supreme judges who claim power to decree the mass murder of Jews, or anyone else, to be legal; and (2) officials who claim they must obey such decrees.

When U.S. Officials conspire to impose Nazi doctrines on the United States, no honest person can doubt that these officials have committed treason to the U.S. Constitution.

America has surrendered the promise that everybody has an unalienable right to life and the purpose of government is to protect the life of everyone. Now the lives of all Americans depend on the whim of officials, as in Stalin's Russia or Hitler's Germany.

The Court claims that it must be obeyed when it imposes Nazi doctrines on America.[42]

5. The United States Being Ruled By A Giant Conspiracy To Mass Murder Is the Most Catastrophic Crime In The History of Civilization.

If U.S. Officials cannot lawfully decree mass murder and

[41] *United States v. Altstoetter* [The Justice Case], 3 Trials of War Criminals before the Nuernberg Military Tribunals 1011-1014 (1951). Hitler claimed the emergency provisions of the Weimar Constitution gave him power to act as the supreme judge. As such he decreed the killing of Jews and other minorities to be legal. The Nazi judges claimed that they could not be held accountable for complicity in extermination and murder, because they had acted "within the authority" of the "decrees" of "the supreme judge." *Id.* at 983-85.
[42] *See* notes 35 and 36, *supra*.

extermination to be liberty, as they officially claim in court, then the United States is now being ruled by a giant conspiracy to mass murder - a conspiracy by the leading U.S. Officials to kill children in defiance of murder statutes.

America introduced civilization to the idea that reverence for life is the future for the world. Yet America is now ruled by the most corrupt decree which the human mind can even imagine - MASS MURDER IS LIBERTY. The government of the United States knows how to build and use atomic bombs, but it does not know the difference between mass murder and liberty. This is the vision which America now holds out to guide the future of the world. Now we all descend into a terrifying darkness.

B.

Roe v. Wade Criminally Defied The Constitution's Guarantee Of Life To "Any Person" Because The Court Defied The Rulings Of Chief Justice John Marshall And Used A "Guilty Until Proven Innocent" Burden Of Proof To Imply That The Words "Any Person" Do Not Include The Unborn.

The Court used the correct burden of proof when it previously construed the words "any person."[43] But in *Roe v. Wade* the Court reversed the burden of proof for the unborn.

1.

Chief Justice John Marshall told the Court what it must prove in order to imply an exception to express and universal terms in the U.S. Constitution.

As already described, the words "any person" are express

[43] The Court ruled the words "any person" included Chinese aliens ("subjects of the emperor of China") and explained that the words are "universal." *Yick Wo v. Hopkins,* 118 U.S. 356, 369 (1886). And the Court was so sure that the words "any person" included "corporations," it refused to allow counsel to argue against it. *Santa Clara v. So. Pac. RR,* 118 U.S. 394, 396 (1886).

and universal, and on their face include the unborn, the same as everybody else. In order to imply an exception to exclude the unborn from the Constitution's guarantee of life, so they can be killed with impunity from criminal laws, the Court must prove that including the unborn within the terms "any person" would be "so monstrous, that all mankind would, without hesitation, unite in rejecting the application."[44]

And the Court must prove that if the right to life of the unborn had "been suggested [to the framers] the language would have been so varied, as to exclude it."[45] The Court must prove that the framers would have changed the Fourteenth Amendment to read: "Nor shall any State deprive any person, **except unborn persons**, of life without due process of law."

These are the burdens which protect the lives of all Americans from government sanctioned extermination, as happened in Hitler's Germany. Obviously, the Court must bear the heaviest burden of proof to imply an exception to the Constitution's guarantee of life to "any person" so millions of victims can be killed with impunity from criminal statutes.

Chief Justice Marshall's rules prove that this guarantee of life to "any person" does include the unborn because "all mankind" would not unite "without hesitation" to exclude the unborn. And the framers of the Fourteenth Amendment

[44] *Sturges v. Crowninshield,* 4 Wheat. 122, 202-203 (1819). When the Constitution uses universal words, and a case is "within the very words of the Constitution," Chief Justice Marshall ruled that the Court may not infer an exception unless the "absurdity and injustice of applying the provision to the case, would be so monstrous, that all mankind would, without hesitation, unite in rejecting the application."

[45] *Dartmouth College v. Woodward,* 4 Wheat. 518, 644-45 (1819). When the Constitution uses universal words, the Chief Justice said, "It is not enough to say that this particular case was not in the mind of the Convention, when the article was framed, nor of the American people, when it was adopted. It is necessary to go farther, and to say that, had this particular case been suggested, the language would have been so varied, as to exclude it, or it would have been made a special exception."

would not have changed its guarantee of life to read "any person, except the unborn." The people had already enacted criminal statutes to protect the lives of the unborn throughout gestation, and some abortions were murder.

Thus the Constitution's universal guarantee of life to "any person" does include the unborn.

2.

But in *Roe v. Wade* the Court exactly reversed the burdens of proof described by Chief Justice John Marshall.

The Court said that the evidence did not prove "with any ***assurance***"[46] that the guarantee of life to "any person" includes the unborn. But "assurance" means "To make certain and put beyond doubt."[47]

Thus in *Roe v. Wade* the Court assumed that the words "any person" did not include the unborn, and then placed the burden on the unborn to prove beyond doubt that the words "any person" did include the unborn.

When courts use this burden of proof to condemn tens of millions of victims to death, Americans cannot pretend they still have a government of Constitution and laws.

The Court claims it can use this burden of proof to decree the extermination of anyone to be liberty.[48]

C.

Roe v. Wade Criminally Defied The Constitution's Guarantee Of Life To "Any Person" Because The Court Used Criminal Procedures To Conclude That The Words "Any Person" Do Not Include The Unborn.

Roe v. Wade was a mock trial designed to exclude truth.[49] And the Court maintains its killings with mock trials. It refuses to allow counsel to represent the unborn and defend the

[46] *Roe v. Wade*, 410 U.S. at 157. (emphasis added)
[47] Black's Law Dictionary (4th ed. 1968).
[48] *See* notes 35 and 36, *supra*.

unborn's right to life. It refuses to allow its false evidence in *Roe v. Wade*, which it used to imply that the words "any person" did not include the unborn, to be confronted and cross-examined. It refuses to allow evidence to be presented to show that the Constitution's guarantee of life to "any person" does include the unborn.

The Nuremberg Tribunal cited such procedures as evidence to convict the Nazi judges of complicity in extermination and murder. It said, "Such a mock trial is not a judicial proceeding but a murder."

D.

Roe v. Wade Criminally Defied The Constitution's Guarantee Of Life To "Any Person" Because The Court Fabricated False Evidence To Conclude That The Words "Any Person" Do Not Include The Unborn.

The history of the criminal abortion statutes proves that the framers of the Fourteenth Amendment did not intend its guarantee of life to "any person" to exclude the unborn.

When the Amendment was adopted in 1868, over three-fourths of the ratifying States had already enacted statutes which made abortion at any stage of gestation a crime.[50] Within a few years, these criminal statutes were universal.

The ancient common law supposed that life commenced at "quickening" - when the mother felt the child stir in her womb. But judicial revision makes it impossible for the Court to assert with assurance that the common law in 1868 was any different than the abortion statutes which were supplanting it. As one 19th century Court observed:

> By the ancient common law...as the life of an infant was

[49] *See* Court's procedures in Motion To Allow Counsel To Represent Children Unborn And Born Alive, filed herein and incorporated by reference. *See also* Ernest, *supra* note 1, at 45-53.
[50] The statutes are set out in Quay, *Justifiable Abortion, Medical and Legal Foundations*, 49 Geo. L. J. 447-520 (1961).

> not supposed to begin until it stirred in the mother's womb, it was not regarded as a criminal offense to commit an abortion in the early stages of pregnancy. A considerable change in the law has taken place in many jurisdictions by the silent and steady progress of judicial opinion; and it has been frequently held by Courts of high character that abortion is a crime at common law without regard to the stage of gestation.[51]

By 1868, medical science had long rejected the ancient notion that life commenced at "quickening." The abortion statutes reflected the views of medical science that there was no time during gestation when the unborn were not alive.

In view of this history, the Court cannot meet its heavy burden to prove that the framers intended to exclude the unborn from the Fourteenth Amendment's guarantee of life to "any person," so they could be killed for convenience. This legislative history is fatal to *Roe v. Wade*.

Thus the Court needed to rewrite 19th century medicine and law. The Court fabricated the hypothesis that the 19th century abortion statutes were intended to protect only the mothers, not the unborn. This suggested that the American people never intended the lives of the unborn to be protected by law. This hypothesis was fabricated as follows.

1.

The Court first asserted as fact, "When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman." *Roe v. Wade*, 410 U.S. at 148. The Court claimed that abortions in the 19th century, even by

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[51] *Lamb v State*, 67 Md. 524 (1887). Some state supreme courts ruled that the common law made abortion at any stage of gestation a crime. *Mills v Comm.*, 13 Pa. 631 (1850); *State v Slagle*, 83 N.C. 544 (1880); *State v Reed*, 45 Ark. 333 (1885).

And those State supreme courts which ruled that abortion prior to quickening was not a common law crime were immediately overruled by their legislatures which made abortion at any stage of pregnancy a crime.

physicians, were hazardous to the woman.

The only authority the Court cited to prove its assertion of fact was a 20th century medical history book.[52] But this book only described the hazards of major surgery in general prior to Lister's discovery of antiseptics. The abortion operation was not mentioned anywhere in the entire book.

The 19th century obstetric authorities throughout the Western world prove that abortions by physicians were "perfectly safe" to the woman.[53] The Court did not examine even one of these obstetric textbooks. They prove the Court's assertion of fact, "the procedure was a hazardous one for the woman," to be false.

The Court never revealed the hazardous abortion procedure to which it was referring. Actually, the 19th century physicians generally used the ancient method,[54] which one physician traced back 2000 years,[55] and which they described as "perfectly safe" to the woman.

Comm. v. Parker, 50 Mass. 263 (1845), was immediately overruled by Mass. Acts & Resolves ch. 27 (1845). *State v Cooper*, 22 N.J.L. 52 (1849), was immediately overruled by N.J. Laws at 266 (1849). *Abrahams v Foshee*, 3 Iowa 274 (1856) was overruled by the next legislature, Iowa Rev. Laws, tit. XXIII, ch. 165. art. 2, sec. 4221 (1860).

[52] Haagensen and Lloyd, *A Hundred Years of Medicine* 19 (1943), cited in *Roe v Wade*, 410 U.S. at 148 n.43.

[53] 2 T. Denman, M.D., *An Introduction to the Practice of Midwifery* 96 (1802). Denman was a standard English medical authority. A French physician wrote "experience has proved that the dangers of the operation are reduced to a small matter." A.L.M. Velpeau, M.D., *A Complete Treatise on Midwifery* 530 (4th Am. ed. 1852). The preeminent American physician wrote "to the mother there is very little danger." H.L. Hodge, M.D., *The Principles and Practice of Obstetrics* 293 (1864).

[54] Dr. Denman, a standard medical authority in England, wrote in 1802: 'the membranes of the ovum are punctured," which permitted "the discharge of the waters," which induced the "action of the uterus," which resulted in the expulsion of the fetus from the womb, which was "perfectly safe" to the woman. 2 T. Denman M.D., *An Introduction to the Practice of Midwifery* 96-99 (1802).

[55] F. Ramsbotham, M.D., *The Principles and Practice of Obstetric Medicine* 724 (4th ed. 1856).

Since abortions by physicians were not hazardous to the mother, the only motivating purpose the abortion statutes could have had was to protect the lives of the unborn from destruction by abortions. Had it been the purpose of the legislators to only protect the mother, then they would have simply required abortions to be performed by physicians.

2.

The Court next asserted as fact, "Abortion mortality was high."[56] The Court cited no authority to support it.

The Court intended this assertion of fact to prove that physicians in the 19th century were killing so many women with abortions that women needed legislation to protect them from the medical profession.

The 19th century obstetric authorities prove this assertion to be false. The obstetric texts show that abortions by physicians were "perfectly safe" to women.

3.

The Court next asserted the conclusion it derived from these two false assertions of fact:

> "[A] State's real concern in enacting a criminal abortion law was to protect the pregnant woman, that is, to restrain her from submitting to a procedure that placed her life in serious jeopardy." *Roe v Wade*, supra, at 149.

This is a false inference, drawn from two false assertions of fact.

The evidence shows these abortion statutes were intended to protect the unborn. The 19th century treatises on criminal law stated that the fetus was "a living being immediately after conception" and these abortion statutes were intended to protect the lives of the unborn during all stages of gestation.[57]

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[56] *Roe v. Wade*, 410 U.S. at 149.

[57] 1 F. Wharton, *A Treatise on the Criminal Law of the United States* 656-57 (5th ed. 1861).

And State supreme courts ruled that these abortion statutes protected the lives of the unborn.[58] And authors of these statutes said their purpose was to protect the unborn.[59]

But since abortions by physicians were known all over the western world to be safe for women, the motivating purpose of these 19th century abortion statutes could only have been to protect the lives of unborn children from destruction by abortions. Since legislatures prohibited safe abortions by physicians, despite the great danger to the mother from abortions by criminals,[60] it proves that their motivating concern was to protect unborn life.

4.

The Court then concluded, "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." *Roe v. Wade*, 410 U.S. at 158. The Court could not find even one 19th century authority to support this result.

In view of these abortion statutes, the Court cannot prove that the people who framed and adopted the Fourteenth Amendment intended its guarantee of life to "any person" to exclude the unborn, so they could be killed for convenience.

5.

The Court resurrected the ancient view that life begins at "quickening" (about four mponths gestation) and arbitrarily expanded that to "viability" (about seven months gestation). Yet, by the time the Fourteenth Amendment was adopted, both science and law had rejected the ancient view.

A physician, who helped draft Virginia's 1848 state abortion statute, explained that science had rejected the ancient view that life began at quickening:

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[58] *Smith v State*, 33 Me 48 (1851).

[59] *See* Joynes, note 61, *infra*.

[60] "In thirty-four cases of criminal abortion...twenty-two were followed ... by death, and only twelve were not. In fifteen cases necessarily induced by physicians, not one was fatal." H.R. Storer, M.D., *On Criminal Abortion in America* 43 (1860).

> (T)hat the embryo is endowed with an inherent vitality from the first moment of conception, and is therefore as much entitled to the protection of the law before the period of "quickening" as after it, every well-informed physician must yield a ready assent. The old doctrine, once held by medical men...that the foetus first becomes animated, or endowed with distinct vitality, at the moment when the sensation of quickening is experienced by the mother, has been long since banished from the domain of science...and now only finds a retreat in the dark and ancient caverns of the common law.
>
> ....
>
> The civil rights of the unborn child are perfect from the very commencement of its being.[61]

In 1860 the President of the American Medical Association condemned that ancient common law view as a "barbarous physiology" and urged the States to enact statutes to protect all stages of unborn life:

> "This relic of a barbarous physiology needs to be exploded, and the truth should be generally promulgated, that, from the moment of conception, a new being is engendered." 13 Transactions of American Medical Association 56-7 (1860)

In 1864 America's most eminent professor of obstetric medicine wrote:

> From the moment of fecundation, the new being becomes independent...its individuality is complete.... (T)here is a progressive...advancing from one degree of perfection to another. Every protection, therefore, which is extended by human legislation to the young infant... should be equally effectual in securing the life of the embryo from the earliest period of its existence.[62]

[61] L.S. Joynes, M.D., *Foetus in Utero*, Virginia Medical Journal 179-180, 187 (1856).

But the Court adopted a view of unborn life which 19th century medical science had rejected as "a barbarous physiology," which courts had ruled "never ought to have been the law anywhere,"[63] and which legislatures had condemned as criminal.

In construing the phrase in its constitution, "Everybody has the right to life," the Federal Constitutional Court of West Germany ruled that the word "everybody" did include the unborn because "No distinction can be made among the several stages of developing life before birth, or between prenatal and postnatal life."[64] Thus that court ruled that the State had a duty to protect unborn life.

The medical and legal history show that the framers and adopters of the Fourteenth Amendment made this same conclusion when they guaranteed life to "any person" without any exceptions for the unborn. They decided that unborn life was a progressive advancing from one degree of perfection to another, and there was no time when the unborn were not alive and the law could withdraw its protection.

Chief Justice Marshall ruled that the intention of the framers is the law. So the Constitution's guarantee of life to "any person" does include the unborn.

The Court claims it can fabricate evidence to exclude anyone from the Constitution's guarantee of life to "any person" so they can be killed with impunity from criminal statutes.[65] The Court effectively asserts Falsehood Is Truth.

[62] H. L. Hodge, M.D., *The Principles and Practice of Obstetrics* 78 (1864). Hodge's "name had become a household word throughout the land" and his book "valued among the very first works on obstetrics ever issued from the American or foreign press." R. Penrose, M.D., *Discourse on Life of H.L. Hodge* 20-21 (1872).

[63] *Mills v. Comm.*, 13 Pa. at 632 (1850).

[64] *See* note 5, *supra*.

[65] *See* notes 35 and 36, *supra*.

E.

Due Process Of Law Has Compelled The U.S. Supreme Court To Confess In Court That It Is Guilty Of Extermination And Murder.

For the **117th time**, the U.S. Supreme Court is accused of defying the Constitution's guarantee of life to "any person" and exterminating millions of victims whom the Constitution endeavors to preserve.

For the **93rd time,** the U.S. Supreme Court is accused of mass murder in violation of State and federal statutes.

For the **97th time**, the U.S. Supreme Court is accused of using criminal procedures to effect and maintain its *Roe v. Wade* killings.

But, for a quarter-century, the Court has never attempted to refute the charges. Failure to deny a charge is admissible as a confession that the charge is true.[66]

As Socrates cross-examined at his trial 2400 years ago:

> "(Y)ou are silent, and have nothing to say. But is not this rather disgraceful, and a very considerable proof of what I was saying?" And "I may assume that your silence gives consent." *Plato*, 41, 45 (Jowett translation, 1942).

And the Court recognizes this ancient rule:

> "(T)he Court has consistently recognized that…silence in the face of accusation is a relevant fact…. Silence is often evidence of the most persuasive character." *Baxter v. Palmigiano*, 425 U.S. at 319 (1976).

Under the Court's own rulings, its silence is an admission that the charges are true:

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[66] 4 Wigmore, *Evidence*, Sec. 1071-1073 (Chadborn rev. 1972). "Underlying the rule is the assumption that human nature prompts an innocent man to deny false accusations and consequently a failure to deny a particular accusation tends to prove belief in the truth of the accusation." *McCormick on Evidence*, Sec. 161 (Cleary ed., 2d ed., 1972). *See also* Ernest, *supra* note 1, at pages 68-72.

> "Failure to contest an assertion, however, is considered evidence of acquiescence only if it would have been natural under the circumstances to object to the assertion in question." *United States v. Hale*, 422 U.S. 171,176 (1975).

The circumstances leave no doubt that the U.S. Supreme Court's silence is a confession that the charges are true.

First, the evidence proves the charges to be true. The Court decreed killings to be "liberty" which States had defined to be "murder." This is mere historical fact. No denial is possible. As Chief Justice John Marshall wrote, "a fact which has existed cannot be made never to have existed."[67]

Second, the charges were made in court, the place designated by law to hear such accusations. The Justices could not lawfully close their eyes on the evidence because they had a legal duty to refute the charges, if they could. Chief Justice John Marshall ruled that judges who "close their eyes on the Constitution" and "condemn to death those victims whom the Constitution endeavors to preserve" commit "crime."[68] The Court had a legal duty to fully hear allegations that *Roe v. Wade* was wrongly decided, and to obey the evidence.

Third, the Court's steadfast silence for a quarter-century in the face of scores of accusations is unparalleled in the legal history of the world. The Court itself cited this circumstance as making confession by silence more trustworthy:

> "Silence gains more probative weight where it persists in the face of accusation, since it is assumed in such circumstances that the accused would be more likely than not to dispute an untrue accusation." *United States v. Hale*, 422 U.S. 171, 176 (1975).

Fourth, the evidence showed the United States was being ruled by a giant conspiracy to exterminate and mass murder.

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[67] *Marbury v. Madison*, 1 Cranch 137, 167 (1802).
[68] *Marbury v. Madison*, 1 Cranch 137, 179-180 (1803).

Never in history had it ever been more imperative to deny charges if they were untrue.

And **fifth**, the Justices met the charges in court by claiming they must be obeyed even if they decreed the mass murder of Jews, or anyone else, to be liberty.[69]

A government of laws can permit only one conclusion to be drawn from these facts: the U.S. Supreme Court has confessed in court that the charges are true.

If *Roe v. Wade* is a mistake of law, then all government officials who helped to support the killings can be prosecuted for complicity in extermination and mass murder.

The general rule is that mistake of law is no excuse for breaking the law.[70] The Constitution's *ex post facto* provisions do not apply to judicial decisions which are a mistake of law.[71] The limited affirmative defense of reasonable reliance on an official judicial opinion, thereafter determined to be a mistake of law, does not apply in homicide cases, much less national extermination.[72] But even if it did, no reliance on *Roe v. Wade* could be reasonable in view of the above facts. So the law applied at Nuremberg applies here: Obedience to decrees of the supreme judge is no defense to complicity in extermination and mass murder.

Even if the U.S. Supreme Court held a gun to a man's head, and threatened death unless he obeyed *Roe v. Wade*, it would not be a defense to complicity in extermination and murder. As Blackstone wrote, "he ought rather to die himself than escape by the murder of an innocent."

In explaining why the Western democracies bowed to violence and the Nazis got away with monstrous crimes, Winston Churchill merely quoted Machiavelli: "Men avenge slight injuries, but not grave ones." Thus America is now ruled by a giant conspiracy to exterminate and murder.

"Political language," wrote George Orwell, "is designed to make lies sound truthful and murder respectable." In his novel *1984*, Orwell described a tyranny which claimed "Whatever the Party holds to be truth is truth," and defrauded its subjects into obedience with its slogans "FREEDOM IS SLAVERY" and "WAR IS PEACE." This science fiction may appear implausible. Yet for a quarter-century the United States has been ruled by a Court which claims, "Whatever the Court holds to be truth is truth," and maintains obedience with its slogans MASS MURDER IS LIBERTY, FALSEHOOD IS TRUTH, and TREASON IS LAW.

But all that will be swept away. The primitive idea, that some can gain by killing others, has no future. The message of our Declaration of Independence becomes more true every day: reverence for life is the only path to the future. Wherever we are, wherever in the universe our kind may go, our essential thought, the thought necessary for us to exist, will always be reverence for life.

CONCLUSION

The Court must uphold the Nebraska abortion statute, overrule *Roe v. Wade*, and proclaim the truth: the U.S. Constitution's universal guarantee of life to "any person," made in its Fifth and Fourteenth Amendments, does include the unborn. State and federal governments have a duty to protect unborn life.

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Counsel

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[69] *See* notes 35 and 36, *supra*.

[70] R. Perkins, *Criminal Law* 920 (2d ed. 1969). Oliver Wendell Holmes, *The Common Law* 41 (1963).

[71] *Ross v. Oregon*, 227 U.S. 150, 161 (1912).

[72] Model Penal Code, Sec. 2.04 Ignorance or Mistake (Proposed Official Draft 1962) and comments in Model Penal Code, Tentative Draft No. 4, Comments on Sec. 2.04, page 138; R. Perkins, *Criminal Law* 928 (2d ed. 1969).

(10)

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IN THE

Supreme Court of the United States

CLERK

OCTOBER TERM, 1999

DON STENBERG, ATTORNEY GENERAL OF THE STATE OF NEBRASKA, ET AL.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

BRIEF AMICI CURIAE OF FEMINISTS FOR LIFE OF AMERICA; MASSACHUSETTS CITIZENS FOR LIFE, INC.; PRO-LIFE LEGAL DEFENSE FUND, INC.; AND UNIVERSITY FACULTY FOR LIFE IN SUPPORT OF PETITIONERS

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This *amici curiae* brief respectfully is submitted on behalf of Feminists for Life of America, Massachusetts Citizens for Life, Inc., Pro-Life Legal Defense Fund, Inc., and University Faculty for Life in support of Petitioners and in favor of reversal of the judgment of the United States Court of Appeals for the Eighth Circuit entered on September 24, 1999. Pursuant to Rule 37.3 of the Rules of this Court, *Amici* have obtained and file herewith the written consent of each of the parties to the filing of this brief.

INTEREST OF THE AMICI CURIAE

Feminists for Life of America ("FFL") is a non-sectarian, grassroots organization incorporated in Delaware in 1972 that seeks true equality for all human beings, particularly women. FFL opposes all forms of violence, in accord with the core feminist principles of justice, non-violence, and non-discrimination. FFL is dedicated to securing basic human rights for all people, especially women and children, from conception until the natural end of life. Among its members are women who oppose the D&X method of abortion as a threat to the lives of women and children. By filing this brief, FFL seeks to advance its general interest in promoting basic human rights, including, but not limited to, the right to life, for all people, especially women and children.

Massachusetts Citizens for Life, Inc. ("MCFL") is a Massachusetts non-profit, grassroots corporation organized to affirm in the public domain the value of all human life from conception to

natural death. Its members include a broad spectrum of citizens from all walks of life. MCFL engages in educational and legislative efforts related to fostering respect for human life and defending the right to life of all human beings, born and unborn. MCFL is presently involved in an effort to ban the D&X procedure in the state of Massachusetts. For these reasons, the issues involved in this case are of acute interest to MCFL.

The Pro-Life Legal Defense Fund, Inc., is a Massachusetts not-for-profit corporation composed of lawyers who provide pro-bono legal services to those engaged in the defense of human life from conception to natural death.

University Faculty for Life is a nonprofit organization incorporated in the District of Columbia and composed of North American University Professors from many disciplines who seek to promote research, dialogue, and publication on the value of human life from its inception to natural death.

SUMMARY OF ARGUMENT

Our system of government is built upon the principles of federalism and separation of powers. It is in the face of divisive and fiercely-debated questions like abortion that these foundational principles are most clearly implicated and, consequently, where abandonment of these principles is most dangerous. The Eighth Circuit's failure to allow for a reasonable narrowing interpretation, its unwillingness to defer to the interpretation of the Nebraska Attorney General, and its willingness to substitute the factual findings of a single court for those of the Nebraska Legislature demonstrate a disregard for federalism and separation of powers that this Court should correct.

First, federal courts should refrain from declaring state statutes facially unconstitutional if a reasonable statutory construction exists. In this case, the lower courts held that the phrase "substantial portion" was so broad that it necessarily encompasses not only Dilation and Extraction (D&X) abortions, but also the more common Dilation and Evacuation (D&E) abortions. In reaching this conclusion, both the District Court and the Eighth Circuit erred by disregarding the possibility that "substantial portion" could reasonably be construed to ban only D&X, or partial birth, abortions. In fact, numerous decisions—both by this Court and by lower courts—have used the word "substantial" to mean "nearly all." This commonplace meaning of "substantial" would limit the statute to a prohibition of the D&X abortion procedure alone, in which nearly all of the fetus is extracted before being killed.

Second, the lower courts accorded no deference to the Nebraska Attorney General's interpretation of the statute, an interpretation that would cabin the statute to its intended purpose of proscribing only the D&X procedure. By virtue of his position, the Attorney General has a unique familiarity with the framing and adoption of this statute, and to adopt his interpretation would demonstrate the comity that our federalism urges. Both the district court and the court of appeals possessed the authority to make the Attorney General's interpretation binding upon all the parties by enjoining them from enforcing the statute against D&E abortions.

Third, the District Court improperly overruled the legislature's finding of fact on the basis of the limited trial testimony presented in court by a few experts. As this Court has recognized, legislatures have a special institutional capacity to research, analyze, and weigh empirical data, particularly in medical and scientific areas. The Nebraska Legislature determined that the D&X procedure is never medically necessary. In the face of this finding, and given the availability of several safe and widely-accepted alternative methods of abortion, banning D&X, either with or without a health exception, does not create an undue burden under *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992).

ARGUMENT

I. CONTRARY TO WELL-ESTABLISHED CANONS OF STATUTORY INTERPRETATION, THE EIGHTH CIRCUIT REJECTED A REASONABLE NARROWING INTERPRETATION.

Although the Eighth Circuit acknowledged its "duty to give [the statute] a construction, if reasonably possible, that would avoid constitutional doubts," the court's construction of the statute disregarded the reasonable possibility that the words "substantial portion" indicate a portion of the fetus sufficiently large so as to exclude the D&E procedure from coverage under the statute. *Carhart v. Stenberg*, 192 F.3d 1142, 1150 (CA8 1999). In concluding that "substantial portion" must encompass a mere arm or a leg, the Eight Circuit ignores this Court's precedent, Eighth Circuit precedent, and the Eighth Circuit's demonstrated understanding of the Nebraska Supreme Court's use of the term "substantial."

When this Court considered the term "substantial" in *Pierce v. Underwood*, 487 U.S. 552 (1988), eight members of this Court[1] agreed that

> the word "substantial" can have two quite different -- indeed almost contrary -- connotations. On the one hand, it can mean "considerable in amount, value or the like; large" -- as, for example, in the statement, "He won by a substantial majority." On the other hand, it can mean "[t]hat is such in substance or in the main," as, for example, in the statement, "What he said was substantially true."

Id. at 564 (internal citations omitted); *see also id.* at 576 (Brennan, J. concurring in part and concurring in the judgment) (quoting the Court's language with approval); *id.* at 584 (White, J., concurring in part and dissenting in part) (concurring in the relevant portion of the Court's opinion); Webster's Ninth New Collegiate Dictionary 1176 (1991) (listing "being largely but not wholly the thing specified" as a definition of "substantial").

Nebraska argues for a construction of "substantial portion" to mean enough of the whole so as not to encompass merely an arm or a leg. Given this Court's discussion in *Pierce*, the Eighth Circuit erred in rejecting this definition as "twist[ing] the words of the law and giv[ing] them

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[1] Justice Kennedy took no part in the decision.

a meaning they cannot reasonably bear." *See Stenberg*, 192 F.3d at 1150.

The Eighth Circuit has, in other contexts, used the term "substantial" to mean precisely what Nebraska suggests its own courts might: something close to the whole. Surely when the Eighth Circuit notes that a statute's definition of abortion is "substantially similar to the definition the Supreme Court found constitutional in *Casey*," *Fargo Women's Health Org. v. Schafer*, 18 F.3d 526, 535 (CA8 1994), or when it explains that the definition of an employer under the ADEA is "substantially the same" as that under Title VII, *Lenhardt v. Basic Inst. of Tech., Inc.*, 55 F.3d 377, 380 (CA8 1995), the court does not mean "substantial" in the "arm or leg" sense but rather in the "almost whole" sense. Moreover, the Eighth Circuit has quoted the Nebraska Supreme Court as interpreting the word "substantial" in precisely this manner:

> While it is difficult to state what the term "substantial performance" or "substantial compliance" as applied to building and construction contracts means, it seems that there is substantial performance of such a contract where all of the essentials necessary to the full accomplishment of the purposes for which the thing contracted for has been constructed are performed with such an approximation to complete performance that the owner obtains substantially what is called for by the contract.

Nathan Constr. Co. v. Fenestra, Inc., 409 F.2d 134, 138 (CA8 1969) (quoting *Jones v. Elliott*, 172 Neb. 96, 108 N.W.2d 742, 748 (Neb. 1961)).

Of course, all of these uses of the term "substantial" are somewhat context-dependent; none discusses what a "substantial portion" of a human body might be. Although the phrase "substantial portion" has been used in connection with the human body in only a few cases, there is nothing to suggest that any court, outside of the partial-birth abortion controversy, has ever used that phrase to mean something so little as an arm or a leg. At least one court has explicitly considered the phrase "substantial portion of the body" in direct opposition to the characterization of a mere arm. *See Thompson-Hayward Chem. Co. v. Peterson*, 56 Ala.App. 432, 435, 322 So.2d 723, 725 (Ala. Civ. App. 1975) ("The Court finds that the plaintiff sustained very serious burns which covered a substantial portion of his body . . . . The defendant contends that the disability is limited to the arm, but the Court finds that the disability extends to the body as a whole . . . ."). Similarly, when a United States District Court states that "[t]he substance unexpectedly and violently exploded, engulfing the plaintiff in flames and severely burning him over a substantial portion of his body," it is difficult to believe that the court means merely an arm or a leg. *Duck v. Gresham-McPherson Oil Co.*, 999 F.Supp. 848, 849 (S.D.Miss. 1998); *see also Hager v. Crepaco, Inc.*, 980 F.Supp. 292, 293 (N.D. Ill. 1997) ("Hager was injured when Clean-in-place ("CIP") machine No. 358 overflowed and splashed lye on a substantial portion of his body."). More important, in the only Nebraska case to use that term in con-

nection with a human body, the court describes pictures as showing injuries to "a substantial portion" of the body, while describing testimony about the same injuries as pertaining to the "entire body." *In Re McCauley*, 3 Neb.App. 474, 477–78, 529 N.W.2d 77, 80–81 (Neb. Ct. App. 1995); *see also State v. Perry*, 124 N.J. 128, 181, 590 A.2d 624, 651 (N.J. 1991) (Stein, J., concurring in part and dissenting in part) (describing a woman who was 60% covered in scalding wounds: "[A] substantial portion of her body showed signs of scalding").

None of these cases, of course, suggests that the term substantial portion as applied to a human body *must* be read to mean something greater than an arm or a leg. They do, however, suggest that the Eighth Circuit was mistaken in ruling that the statutory term "substantial portion" would have to be "twisted" in order to mean something more than an arm or leg. *See Stenberg*, 192 F.3d at 1150. Clearly, "substantial portion" can reasonably bear the meaning for which Nebraska argues.

II. THE EIGHTH CIRCUIT FAILED TO GIVE DUE DEFERENCE TO THE NEBRASKA ATTORNEY GENERAL'S NARROWING INTERPRETATION.

The Nebraska Attorney General has offered a narrow interpretation of the partial-birth abortion statute consistent with the manifest intentions of the Legislature and people of Nebraska. This Court has recognized that federal courts should take heed of interpretations offered by a state's

executive branch or enforcement authorities, so as to avoid needless interference with important state policies. In one case, this Court referred to constructions offered by a State Personnel Board and the State's Attorney General as "authoritative pronouncements" that a federal court should not ignore "in determining the breadth of a statute." *Broadrick v. Oklahoma*, 413 U.S. 601, 617–18 (1973). In another case involving an overbreadth challenge to a city ordinance that penalized "picketing before or about the residence or dwelling of any individual," this Court accepted a narrowing interpretation offered by the "counsel for the town at oral argument." *Frisby v. Schultz*, 487 U.S. 474, 477, 483 (1988).

This tradition of deference to state and local enforcement authorities on interpretive questions has a long pedigree. As the Court said in *Ward v. Rock Against Racism*, 491 U.S. 781 (1989), "[I]n evaluating a facial challenge to a state law, a federal court must . . . consider any limiting construction that a state court *or enforcement agency* has proffered." *Id.* at 795–96 (quoting *Hoffman Estates v. The Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 494 n.5 (1982)) (emphasis added). *See also Board of Educ. of Rogers v. McCluskey*, 458 U.S. 966 (1982) (deferring to a school board's interpretation of its rules); *Law Students Civil Rights Research Council, Inc. v. Wadmond*, 401 U.S. 154, 162 (1971) (considering a challenge to the constitutionality of questions asked by state bar authorities, and deferring to the state bar's narrowing interpretation of those questions); *Fox v. Standard Oil Co. of New Jersey*, 294 U.S. 87, 96 (1935) (considering a state tax statute and giving a state tax commissioner's contemporaneous in-

terpretation "respectful consideration"); *United States v. Moore*, 95 U.S. 760, 763 (1877) ("The construction given to a statute by those charged with the duty of executing it is always entitled to the most respectful consideration, and ought not to be overruled without cogent reasons."); *Hope Clinic v. Ryan*, 195 F.3d 857, 871 (CA7 1999) ("[W]e believe that state courts are entitled to accept the view of both states' Attorneys General that their laws do not forbid, or even affect, the D&E procedure.").

Given this history of deference to state and local enforcement authorities regarding statutory interpretation questions, the Court should recognize the persuasive authority of the Attorney General's opinion construing the Nebraska partial-birth abortion statute as applying only to D&X abortions. Such a recognition of the Attorney General's construction would demonstrate the Court's willingness to give state authorities the respect and deference they deserve on issues peculiarly within their domain.

III. ALLOWING FOR THE NARROWING CONSTRUCTION DOES NOT IMPLICATE THE DANGERS ADDRESSED BY THE OVERBREADTH AND VAGUENESS DOCTRINES.

The traditional concerns underlying the void-for-vagueness doctrine include the fear of a chilling effect due to a failure to provide fair warning to those affected by the law, and the fear of arbitrary and unjust enforcement. As this Court

noted in *Grayned v. Rockford*, 408 U.S. 104 (1972):

> It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined. Vague laws offend several important values. First, because we assume that man is free to steer between lawful and unlawful conduct, we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning. Second, if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them. A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory application.

Id. at 108–09.

A. Acknowledging a Narrower Scope for the Statute Eliminates Any Lingering Chilling Effect the Law Might Have on Constitutional Conduct.

At least two federal judges have recently suggested that narrowing interpretations of an allegedly vague or overbroad statute do not eliminate the statute's chilling effect. *See, e.g., Hope Clinic v. Ryan*, 195 F.3d 857, 889–90 (CA7 1999) (Posner, J., dissenting) ("And now we can see more clearly one of the fallacies in the 'precautionary' injunction gimmick. It is the existence of these statutes, because of their extraordinary breadth and the limited incentive of a physician to test their scope, not the risk of prosecution, which may indeed be slight, that burdens those abortion rights that are conceded to be constitutionally protected."); *Richmond Med. Ctr. For Women v. Gilmore*, 55 F.Supp.2d 441, 444 (E.D. Va. 1999) ("[A]n important difference between interpretation of a state statute by a federal court and by a state court is that only the latter interpretation is authoritative . . . . Therefore, when tasked with construing a state law that implicates federally protected rights, a federal court must be cognizant that *an overly narrow, yet non-authoritative, interpretation does not dispel the chilling effect* of the statute's plain terms.") (emphasis added).

The concern about such a chilling effect is misguided, especially with respect to an abortion law that can be construed more narrowly by this Court. These arguments imply that something different happens to the language of the statute if it is limited rather than repealed; put another

way, they suggest that a lingering chilling effect emanates from the terms of the statute if it is merely limited, and therefore to avoid this, the statute should be invalidated entirely. In the first instance, such an argument ignores the practical reality that abortion practitioners are medical specialists who have efficient networks through which they share information and are well-advised of developments in the law. *See, e.g.*, National Abortion Federation, About the National Abortion Federation (visited Feb. 17, 2000) <http://www.prochoice.org/aboutnaf/index.htm> (noting that the NAF "is the professional association of abortion providers in the United States and Canada . . . [which] provides accredited continuing medical education, develops innovative training materials . . . [and provides] legal guidance.") Moreover, abortion practitioners have for many years looked to court opinions, rather than code books, to define the scope of permissible conduct. There is no realistic possibility that a practitioner would read the Nebraska Revised Code and know of the statute—so as to be chilled in her conduct—but simultaneously be unaware of this Court's or the Eighth Circuit's statement that the statute would be unconstitutional if applied to D&E abortion. If such a doctor did exist, however, and was aware of the statute but not aware of the interpreting opinion, the chilling concern would be, *a fortiori*, beyond the court's reach. Courts can invalidate laws, but they cannot repeal them. *See* Richard Fallon, As-Applied and Facial Challenges and Third-Party Standing, 113 Harv. L. Rev. (forthcoming Apr. 2000) ("A court has no power to remove a statute from the statute books."); *Jawish v. Morlet*, 86 A.2d 96, 97

(D.C. Mun. Ct. App. 1951) (agreeing that "a statute declared unconstitutional is void in the sense that it is inoperative or unenforceable, but not void in the sense that it is repealed or abolished."). Thus, a doctor who was unaware of a narrowing interpretation in a court opinion would be equally unaware of an overruling in a court opinion — if the doctor knew only the statute, that will remain the same, regardless of whether a court upholds, partially upholds, or invalidates the law.

Courts are rarely, if ever, concerned that the words of a completely invalidated statute left on the books will chill constitutional conduct after the court's decision. *Cf.* William Michaels Treanor & Gene B. Sperling, Prospective Overruling and the Revival of "Unconstitutional" Statutes, 93 Colum. L. Rev., 1902, 1922 (1993) (noting "seventeen unenforced but unrepealed pre-Roe criminal abortion statutes" as of 1993). That same equanimity should exist when narrowing, but not invalidating, a statute; both actions will have precisely the same power to eliminate chilling effects. Either the doctor will be aware, and thus will be informed by the court as to what behavior is constitutionally protected, or the doctor will be unaware and informed only by the statute, in which case the court's opinion will not reach her or him in any event.

B. Because the Court Has the Power to Bind All Parties Before It, There Is No Risk of Arbitrary Enforcement with this Statute.

The second concern of the void-for-vagueness doctrine is the fear of arbitrary enforcement. In this case, however, the fear of arbitrary enforcement is without basis in empirical fact. The Nebraska Attorney General – speaking for the state of Nebraska – has provided an interpretation of the statute that limits its prohibition to D&X abortions, *i.e.*, to those abortions in which the fetus is pulled out up to the head before being killed. Thus, even if this statute had never been challenged in court, the chance of enforcement as to D&E abortions would be slim. Moreover, if this Court adopts the Attorney General's interpretation by ruling unconstitutional the application of the Nebraska statute to D&E abortions, then the chance of arbitrary enforcement will be nonexistent. After all, this Court's reach over prosecutors is a constant, regardless of whether it enjoins enforcement of the statute entirely or only partially. *Cf.* Fallon, *supra* (suggesting that the binding power of a court's ruling turns not on whether a challenge is facial or as applied but on doctrines of claim preclusion, issue preclusion, and precedent.) Thus, by accepting the proffered narrowing interpretation and declaring that any broader interpretation would be unconstitutional, this Court can prevent arbitrary enforcement.

IV. GIVEN PROPER DEFERENCE TO LEGISLATIVE FINDINGS OF FACT, THE NARROWING INTERPRETATION OF THE STATUTE DOES NOT CREATE AN UNDUE BURDEN.

If either lower court had accepted the reasonable narrowing interpretation, the only remaining potential ground for invalidation would be the absence of a maternal health exception. But such an exception is unnecessary where safe alternative abortion procedures exist. The District Court determined that the most common late-term abortion procedure was insufficiently safe as an alternative to D&X. In so doing, the District Court erred by disregarding the facts as found by the legislature of Nebraska. Properly deferred to, the legislative facts make clear that, even without a health exception, banning D&X abortions does not create an undue burden under *Casey*.

A. The Nebraska Legislature Made a Reasonable Finding of Fact, Supported by Substantial Evidence, That D&X Abortion Is Never Medically Necessary.

Whether D&X abortions are ever medically necessary is properly an issue of legislative fact. As Judge Posner explained: "The issue is whether the Wisconsin and Illinois 'partial birth' statutes impose an undue burden, and specifically whether they are a threat to maternal health. That is rightly an issue of legislative fact . . . ." *Hope Clinic v. Ryan*, 195 F.3d 857, 885 (CA7 1999).

While Congress and other legislatures may sometimes prefer to state their factual findings explicitly, they are not required to do so. Rather, findings are often implicit or obvious from the text of the law and the legislative history. *See, e.g., FCC v. Beach Communications, Inc.*, 508 U.S. 307, 315 (1993) ("[W]e never require a legislature to articulate its reasons for enacting a statute. . . . [T]he absence of legislative facts . . . on the record has no significance . . . .") (internal quotation marks omitted); *United States Railroad Retirement Bd. v. Fritz*, 449 U.S. 166, 179 (1980) ("[T]his Court has never insisted that a legislative body articulate its reasons for enacting a statute. This is particularly true where the legislature must necessarily engage in a process of line-drawing.").

It is clear that the Nebraska Legislature found that D&X is never medically necessary to preserve maternal health. The Legislature explicitly considered that such an exception may be constitutionally required if D&X abortion were ever medically necessary. *See* Trial Court Exhibit 30, Floor Debate on LB 23 (June 2, 1997) at 9247 – 48. Legislators offered, debated, and declined to adopt several health exception amendments. *See, e.g., id.* at 6417 (amendment AM1966, proposed May 12, 1997 and defeated 20-11); *id.* at 7758 (amendment AM2325, proposed May 20, 1997 and withdrawn). Indeed, the deliberative process on this issue spanned several months, and included the testimony of numerous experts before the Judiciary Committee. *See generally id.* at 3955-9471. The law passed in its current form with only one dissenting vote. *See id.* at 9471.

The Legislature's finding was reasonable and based on extensive medical evidence. In addition

to both the testimony presented at Judiciary Committee hearings and the protracted floor debate, the Legislature took note of the opinions offered by the medical community within the context of the federal partial birth bill. *See, e.g., id.* at 9425 (discussing AMA support). For example, a panel of ACOG representatives indicated that they could identify no set of circumstances under which D&X was medically necessary, given the availability of alternative procedures. *See Hope Clinic v. Ryan*, 195 F.3d 857, 872 (CA7 1999). A policy statement by the AMA agrees. *See id.* (citing AMA Policy H-5.982). Further, the absence of any peer-reviewed studies comparing the health implications of D&X with other abortion techniques supported the Legislature's judgment that the banned D&X procedure is outside the medical mainstream and is never medically required.

B. Federal Courts Have a Long and Sensible Tradition of According Deference to Legislative Findings of Fact.

Federal courts traditionally accord deference to state and federal legislative findings of fact. *See Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 463–65 (1981) ("States are not required to convince the courts of the correctness of their legislative judgments. Rather, those who challenge the legislative judgment must convince the court that the legislative facts on which the classification is apparently based could not reasonably be conceived to be true by the governmental decisionmaker.") (quoting *Vance v. Bradley*, 440 U.S.

93, 111 (1979) (internal quotation marks omitted)); *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 500 (1989) ("The factfinding process of legislative bodies is generally entitled to a presumption of regularity and deferential review by the judiciary.") (citing *Williamson v. Lee Optical of Oklahoma, Inc.*, 348 U.S. 483, 488–89 (1955)).

It is particularly significant that this type of judicial deference is granted to legislative facts even when fundamental liberties are implicated. *See, e.g., Gregg v. Georgia* 428 U.S. 153, 176 (1976) (opinion of Stewart, Powell, and Stevens, JJ.) (noting, in the Eighth Amendment context, the "deference [courts] owe to state legislatures under our federal system."); *Harmelin v. Michigan* 501 U.S. 957, 959 (1991) (noting that under Eighth Amendment "reviewing courts should grant substantial deference to legislative determinations"); *Clover Leaf Creamery*, 449 U.S. at 463–65 (affording deference to legislative facts in Equal Protection case under Fourteenth Amendment); *Turner Broadcasting Sys., Inc. v. F.C.C.*, 520 U.S. 180, 195 (1997) ("Even in the realm of First Amendment questions where Congress must base its conclusions upon substantial evidence, deference must be accorded to its findings as to the harm to be avoided and to the remedial measures adopted for that end, lest we infringe on traditional legislative authority to make predictive judgments when enacting nationwide regulatory policy.").

This policy of deference is grounded in a functionally sound understanding of the special institutional competency of legislative bodies. Legislatures enjoy a comparative advantage over courts in making the factual determinations necessary for policy initiatives. Legislatures are equipped

with resources for protracted analysis and empirical study of the many factors affecting public policy initiatives. *See Turner Broadcasting,* 520 U.S. at 195 ("We owe Congress' findings deference in part because the institution is far better equipped than the judiciary to amass and evaluate the vast amounts of data bearing upon legislative questions."); *see also Anheuser-Busch, Inc. v. Schmoke*, 63 F.3d 1305, 1312 (CA4 1995), *vacated on other grounds*, 517 U.S. 1207 (1996) ("[T]he government's burden of justifying its legislative enactment against a facial challenge may be carried by pointing to the enactment itself and its legislative history. These are 'legislative facts,' the substance of which cannot be trumped by the fact finding apparatus of a single court.").

The legislative factfinding process merits special deference in areas in which there is conflict or uncertainty among medical and scientific experts. *See, e.g., Jones v. United States,* 463 U.S. 354, 365 (1983) ("The lesson we have drawn is not that government may not act in the face of this [medical and scientific] uncertainty, but rather that courts should pay particular deference to reasonable legislative judgments."). Courts have reviewed legislative facts deferentially in the areas of mental health and substance abuse. In fact, this Court recently reiterated its policy of deference to legislatures faced with medical disagreements. Considering a state civil commitment statute enacted amidst medical disagreements over recidivism, the court stated:

> These disagreements, however, do not tie the State's hands in setting the bounds of its civil commitment laws.

> In fact, it is precisely where such disagreement exists that legislatures have been afforded the widest latitude in drafting such statutes. . . As we have explained regarding congressional enactments, when a legislature undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious not to rewrite legislation.

Kansas v. Hendricks, 117 S.Ct. 2072, 2081 n.3 (1997) (internal quotation marks omitted).

Although the medical necessity of the D&X procedure has been the subject of disagreement among medical professionals, the legislature of the state of Nebraska overwhelmingly found that it was *not* medically necessary. This is precisely the type of situation in which this Court has consistently urged deference.

Thus this Court's precedents—and the sound logic that supports those precedents—suggest that courts should not lightly disregard legislative findings of fact. Although this Court has yet to establish a required level of deference, the standard announced for deference to legislative facts in *Turner Broadcasting* appears well-suited to the task: the legislature must have made "reasonable inferences based on substantial evidence." *See Turner Broadcasting,* 520 U.S. at 195 (quoting *Turner Broadcasting Sys., Inc. v. F.C.C.*, 512 U.S. 622, 666 (1994)). This standard calls for more rigorous evaluation than a rational basis test would require, but less than strict scrutiny.

Given that this Court has shown deference to legislative determinations of facts in such a wide variety of sensitive constitutional areas—including, as noted above, the First, Eighth, and Fourteenth Amendments—this standard should be adopted in the instant case. Because Nebraska's factual findings were reasonable and supported by substantial evidence, they merit deference.

C. When the Legislative Finding Is Accepted, the Statute Needs No Health Exception and Does Not Impose an Undue Burden.

Given the availability of other safe and widely-accepted abortion procedures, a ban on D&X abortions does not impose an undue burden and should not require a health exception. If D&X is never medically necessary, then providing a health exception achieves no gain for women; no constitutional liberties are advanced by adding a provision that can never be invoked. The statute would be internally contradictory, and such an exception would be mere surplusage. This Court has repeatedly noted that it has "a duty to give effect, if possible, to every clause and word of a statute." *Hoffman v. Conn. Dep't of Income Maintenance*, 492 U.S. 96, 103 (1989) (quoting *United States v. Menasche*, 348 U.S. 528, 538–39 (1955)). In light of this practice, it is difficult to believe that the Constitution requires the insertion of a meaningless provision.

This reasoning is confirmed by this Court's decision in *Mazurek v. Armstrong*, 520 U.S. 968 (1997) (upholding Mont. Code Ann. § 50-20-109

(1995)). There, the Court upheld a requirement that abortions be performed by licensed physicians without even mentioning the fact that the law contained no exception for the life or health of the mother. *See* Mont. Code Ann. 50-20-109 (1995). Presumably, the Court allowed the statute to stand without such an exception because it implicitly found that it would not be in the interests of the mother to have abortions performed by a non-physician. Alternatively, it is possible that the Court felt that, even if there were situations in which it would be in the mothers' interests, those situations were so rare as to present no undue burden under *Casey*. Either rationale supports upholding the D&X ban without a health exception: because D&X was found by the legislature never to be medically necessary, omitting an exception is constitutionally permissible and is not an undue burden under *Casey*.

CONCLUSION

For the foregoing reasons, we respectfully request that this Court reverse the judgments of the District Court and Court of Appeals.

Respectfully submitted,

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IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1999

DON STENBERG, ATTORNEY GENERAL OF THE STATE OF NEBRASKA, ET AL.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF *AMICUS CURIAE* OF THE UNITED STATES CATHOLIC CONFERENCE; NEBRASKA CATHOLIC CONFERENCE; ETHICS AND RELIGIOUS LIBERTY COMMISSION OF THE SOUTHERN BAPTIST CONVENTION; GREEK ORTHODOX ARCHDIOCESE OF AMERICA; CHURCH OF JESUS CHRIST OF LATTER-DAY SAINTS; THE LUTHERAN CHURCH-MISSOURI SYNOD; AND NATIONAL ASSOCIATION OF EVANGELICALS IN SUPPORT OF PETITIONERS

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Nancy Romer, M.D., Pamela Smith, M.D., Curtis Cook, M.D., & Joseph DeCook, M.D., "Partial Birth Abortion is Bad Medicine," *Wall Street Journal*, Sept. 19, 1996 21

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MISCELLANEOUS:

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James Tunstead Burtchaell, RACHEL WEEPING (1982) 16

H. Tristram Engelhardt, "Ethical Issues in Aiding the Death of Young Children," in Marvin Kohl (ed.), BENEFICENT EUTHANASIA (1975). 17

Letter of Nov. 6, 1995 from Professor Laurence Tribe to Senators Barbara Boxer and Edward Kennedy 10

Letter of May 8, 1997, to U.S. Senators, signed by 63 Professors of Law, reprinted at 143 Cong. Rec. S4706 (May 20, 1997) 10

Letter of June 13, 1997, from C. Everett Koop, M.D., to Mark A. Levine, Chairman, Reference Committee B, American Medical Association 19

The New York Times, May 26, 1997 (letter from AMA President Daniel H. Johnson, Jr., M.D., to the editor) 19,21

Peter Singer, RETHINKING LIFE AND DEATH: THE COLLAPSE OF OUR TRADITIONAL ETHICS (1994) 17

Michael Tooley, ABORTION AND INFANTICIDE (1983) 17

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1999

DON STENBERG, ATTORNEY GENERAL OF THE STATE OF NEBRASKA, ET AL.,
Petitioners,

v.

LEROY CARHART, M.D.,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF *AMICUS CURIAE* OF THE UNITED STATES CATHOLIC CONFERENCE; NEBRASKA CATHOLIC CONFERENCE; ETHICS AND RELIGIOUS LIBERTY COMMISSION OF THE SOUTHERN BAPTIST CONVENTION; GREEK ORTHODOX ARCHDIOCESE OF AMERICA; CHURCH OF JESUS CHRIST OF LATTER-DAY SAINTS; THE LUTHERAN CHURCH-MISSOURI SYNOD; AND NATIONAL ASSOCIATION OF EVANGELICALS IN SUPPORT OF PETITIONERS

INTEREST OF *AMICI*

Representatives of diverse religious communities unite here across denominational lines as *amici curiae* on behalf of Petitioners to demonstrate that Nebraska may, as it has here,

prohibit the killing of partly-born children.[1] As religious communities, many of these *amici* have worked to restore constitutional protection for life in the United States. As much as we continue to work for reconsideration of this Court's abortion jurisprudence, this case does not require the Court to reevaluate its earlier abortion decisions, for the prohibited conduct falls outside the bounds established under those decisions. The challenged Nebraska law reasonably and constitutionally advances traditional state interests in protecting life and regulating the medical profession. Individual statements of interest follow.

The United States Catholic Conference is a nonprofit corporation organized under the laws of the District of Columbia. Its members are the active Catholic Bishops in the United States. The Catholic Bishops of Nebraska are, in addition, members of the Nebraska Catholic Conference. Both Conferences are vehicles through which the Bishops can speak cooperatively and collegially on matters affecting the Catholic Church, its people, and society in general. The Conferences advocate and promote the pastoral teaching of the Church on diverse issues, including the protection of human rights and the sanctity and dignity of human life. The United States Catholic Conference and Nebraska Catholic Conference have supported initiatives in Congress and in the Nebraska Legislature, respectively, to prevent the killing of partly-born infants.

The Ethics and Religious Liberty Commission is the moral concerns and public policy agency of the Southern Baptist

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[1]Letters from all parties consenting to the filing of this brief have been filed with the Clerk of the Court. Pursuant to this Court's Rule 37.6, counsel for a party did not author this brief in whole or in part. No person or entity, other than the *amici curiae*, their members, or counsel made a monetary contribution to the preparation or submission of this brief.

Convention, the Nation's largest Protestant denomination, with over 16 million members in 40,000 autonomous local churches. The Commission is charged with addressing public policies affecting the sanctity of human life, ethics, and religious liberty.

The Greek Orthodox Archdiocese of America is a nonprofit corporation organized under the laws of the State of New York. It includes over 500 parishes serving a constituency of approximately one million people. In official resolutions, the Greek Orthodox Archdiocese is committed to defending religious freedom and the right to life as treasured gifts of God. It seeks to advocate positions consistent with these resolutions and with its teachings for nearly 2000 years by joining in the filing of briefs in important litigation such as the present case.

The Church of Jesus Christ of Latter-day Saints is an unincorporated religious association with headquarters in Salt Lake City, Utah. Church membership exceeds 11 million, with more than 25,000 congregations throughout the world. Church membership in Nebraska exceeds 18,000, with 340 local congregations. The Church of Jesus Christ of Latter-day Saints believes in the sanctity of life and denounces partial birth abortion.

The Lutheran Church-Missouri Synod (the "Synod") is the second largest Lutheran denomination in North America. It is composed of approximately 6,000 member congregations which, in turn, have approximately 2,600,000 individual members. In 1998, in its most recent convention, the Synod re-affirmed its belief in the sanctity of human life, including "unborn children, whom God has woven together in their mother's wombs (Psalm 139:13-16)." It was resolved that the Synod "denounce partial-birth abortion as a barbaric procedure."

The National Association of Evangelicals ("NAE") is a

nonprofit association of evangelical Christian denominations, churches, organizations, institutions and individuals. It includes some 43,500 churches from 74 denominations and serves a constituency of approximately 27 million people. NAE is committed to defending religious freedom and the right to life as precious gifts of God and vital components of the American heritage.

SUMMARY OF ARGUMENT

In its most recent substantive ruling on the abortion issue, this Court confirmed that not all abortions (let alone all procedures that might be characterized as abortion) are entitled to constitutional protection. *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), reaffirmed that abortions can be prohibited after viability except in those rare circumstances where maternal life or health is endangered. *Casey* left the states free to advance their interests in protecting unborn human life, preserving a woman's health, ensuring that her decision to have an abortion is informed, and regulating and maintaining the integrity and ethics of the medical profession.

Shortly after *Casey* was handed down, it was announced that a handful of physicians were performing a procedure in which all but the head of a child is delivered before his or her life is taken. In such cases, death is caused by forcing scissors into the base of the skull of the partly-born child and suctioning out brain matter. The procedure was claimed by its practitioners to be an innovation. Other physicians and commentators were not so sanguine. A description of the procedure shocked the public, whose representatives in Congress and in state legislatures, including Nebraska, moved to ban it.

In prohibiting the killing of partly-born children, the Nebraska Legislature acted reasonably and in a manner

consistent with this Court's decisions. Those decisions have involved the taking of a child's life *in utero*. Abortion that this Court has held to be constitutionally protected has never been understood by the Court or the public to include taking the life of a partly-born child. The challenged statute prohibits a new procedure which this Court has, until now, never considered. It is called "abortion" because it prevents a completed live birth, but it is in fact an extension of abortion as that procedure has traditionally been understood. The procedure is more like infanticide than abortion. To strike down the Nebraska statute would require an extension of the *Roe/Casey* framework that is unwarranted by constitutional text and existing precedent.

Even if the Court were to consider whether the prohibited conduct should be included within the *Roe/Casey* framework, the considerations identified by the *Casey* plurality would not require extending constitutional protection to that conduct. The "rule of *stare decisis*," upon which the *Casey* plurality relied, 505 U.S. at 846, is not at issue here because the killing of partly-born children is new to both law and medicine. Similarly, "principles of institutional integrity," *Casey*, 505 U.S. at 845, another important concern of the *Casey* plurality, would not be undermined by allowing Nebraska to prohibit the killing of partly-born children when it seems clear that neither the Constitution nor this Court's precedents prevent Nebraska from enacting that prohibition.

Even if the *Roe/Casey* framework were to be applied, the Nebraska statute should be upheld because it furthers legitimate state interests that *Casey* recognized. The statute halts a practice that borders on, if it does not constitute, infanticide, for the child's life is taken when he or she is mere seconds and inches from complete delivery. The statute advances the State's paramount interests in protecting human life and erecting a barrier against outright infanticide. The statute also protects the

integrity and ethics of a profession committed to healing. Indeed, past experience with abortion suggests that if a license to heal became a license to kill partly-born children, such deadly acts would become part of mainstream medicine, eventually forcing conscientious physicians either to conform or to withdraw from areas of practice in which such conduct is expected. Finally, there is substantial and credible evidence that the Nebraska statute poses no risk to women's health. Indeed, many physicians have suggested that the banned procedure itself poses a serious risk to women.

For all these reasons, the Nebraska Legislature acted well within constitutional parameters when it enacted the statute challenged here.

ARGUMENT

This case involves a practice that, since it was announced in 1992, has justifiably horrified the American public. The announced "innovation" in abortion practice, the killing of partly-born children[2] by a handful of physicians, led

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[2]The news was unsettling to individuals on both sides of the abortion debate. Senator Daniel Patrick Moynihan (D. N.Y.) observed that the prohibited conduct "is as close to infanticide as anything I have come upon." Quoted in Nat Hentoff, "Close to Infanticide," *The Washington Post* (Aug. 30, 1996) at A31; *see also* M. LeRoy Sprang, M.D. & Mark G. Neerhof, D.O., "Rationale for Banning Abortions Late in Pregnancy," 280 J. Am. Med. Ass'n 744, 745 (Aug. 26, 1998) ("many otherwise prochoice individuals have found [this procedure] too close to infanticide to ethically justify its continued use"). One physician testified before Congress that "when I describe[d] the procedure of partial-birth abortion to physicians and lay persons who I know to be prochoice, many of them were horrified to learn that such a procedure was even legal." *Partial-Birth Abortion: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. 39 (June 15, 1995) (statement of Pamela Smith, M.D.).

to the approval of prohibitions by Congress[3] and a majority of state legislatures.[4] Judges, though they disagree in their evaluation of these statutes, have universally shared in the public's and legislatures' revulsion to the prohibited conduct.[5]

The constitutional challenge to the Nebraska statute and similar legislation is a truly extraordinary chapter in American law. In cases such as this one it is contended that the killing of partly-born children is not only a public *good* -- a claim that would seem to turn any ordinary understanding of the common good on its head -- but a constitutional *right* with which the state may not interfere. That Respondent or anyone would seriously

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[3]The Partial-Birth Abortion Ban Act, S. 939, 104th Cong., was approved by the Senate on December 7, 1995, approved by the House on March 27, 1996, and vetoed by the President on April 10, 1996. The Partial-Birth Abortion Ban Act of 1997, H.R. 1122, 105th Cong., was approved by the House on March 20, 1997, approved by the Senate with an amendment on May 20, 1997, and the House approved the Senate version on October 8, 1997; that bill was vetoed by the President on October 10, 1997. Thus far, congressional efforts to override the President's veto have passed in the House but narrowly failed in the Senate. On October 21, 1999, the Senate passed the Partial-Birth Abortion Ban Act of 1999, S. 1692, 106th Cong.

[4]*See* note 8, *infra* (listing statutes).

[5]*Evans v. Kelley*, 977 F.Supp. 1283, 1319 n.38 (E.D. Mich. 1997) ("[T]he intact D&E procedure is gruesome and inhumane and society, through its elected representatives, should be able to circumscribe its utility. Indeed, even Plaintiffs' expert, Dr. Doe, testified that the intact D&E is a particularly hideous procedure"); *Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187, 213 (6th Cir. 1997) (Boggs, J., dissenting) (stating that the prohibited procedure is "particularly offensive"), *cert. denied*, 118 S.Ct. 1347 (1998); *Midtown Hospital v. Miller*, 36 F.Supp.2d 1360, 1366 (N.D. Ga. 1997) (characterizing the prohibited procedure as "particularly gruesome and inhuman").

dispute that states have the authority to protect children mere seconds and inches from full delivery[6] from the brutal and violent killing that Nebraska here has chosen to prohibit is perhaps a sign of just how far from a correct interpretation of the Constitution proponents of this procedure are willing to lead this Court.

I. The Killing of Partly-Born Children is Not Constitutionally Protected Under *Roe*, *Casey*, or Other Decisions of this Court.

In *Roe v. Wade*, 410 U.S. 113 (1973), this Court indicated that it was protecting a limited constitutional right -- that a woman could choose whether to terminate or continue a pregnancy without undue interference by the state. *See Maher v. Roe*, 432 U.S. 464, 473-74 (1977). Although it placed this right within a constitutional framework, this Court nevertheless concluded that "this right is not unqualified and must be considered against important state interests in regulation." *Roe v. Wade*, 410 U.S. at 154. Rather, it is a decisional right only, and abortion practices have been protected by this Court only when inexorably linked to the decision whether to continue a pregnancy, something which cannot be said of the conduct at issue here.

In 1992, this Court in *Casey* confirmed the limitations on constitutional abortion and the inherent authority of legislatures to draw appropriate lines. *Casey* reaffirmed the right of women to have an abortion before viability and, after viability, in those

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[6] *Partial-Birth Abortion: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. 39 (June 15, 1995) (testimony of Pamela Smith, M.D.) (testifying that the prohibited conduct "is literally seconds and inches away from being classified as a murder by every State in the Union").

"rare circumstances" in which an abortion is necessary to preserve the mother's life or health. 505 U.S. at 851, 879. Seven justices, however, explicitly rejected the expansive jurisprudence which had developed in the years following *Roe*. *Id.* at 869-78 (plurality opinion); *id.* at 944 (Rehnquist, C.J., joined by White, Scalia, Thomas, JJ.) (concurring in the judgment in part, dissenting in part). The plurality opinion in *Casey* returned to the states the power to regulate abortion and to protect unborn human life throughout pregnancy as long as the state did not "unduly burden" the decision whether to have an abortion before viability. Against this background, it seems patent that simply labeling an action "abortion" does not trigger constitutional protection. Numerous practices, and even some actions properly denominated "abortion," fall outside the *Roe/Casey* constitutional box. The Nebraska statute does not affect the decision to have an abortion, nor does it involve the *in utero* destruction of human life. Nor does it involve a method that has been part of abortion practice. To affirm the lower courts' decision to strike down the statute would therefore involve this Court in constitutionalizing a new and different type of conduct. It would be both a repudiation of *Casey* and a return to the absolutist approach that seven members of this Court rejected in that case.

Neither *Roe* nor *Casey*, nor any other decision of this Court, forbade legislatures to prohibit the killing of children who are partly born. *Roe* speaks directly to this point. All that was challenged in *Roe* was a Texas ban on abortion *before* the birth process begins. *Roe* explicitly exempted from its consideration a Texas law that made it unlawful "during parturition of the mother [to] destroy the vitality or life in a child in a state of being born and before actual birth...," 410 U.S. at 117 n.1, a prohibition which came under no attack in *Roe*, and which continues to this day following its recodification in 1973.

Tex. Rev. Civ. Stat. art. 4512.5.[7] *Roe*, then and now, has been understood by this Court and the American public as relating to the taking of life *in utero*.

No subsequent decision of this Court has ever extended *Roe* to encompass the death of partly-born children.[8] Indeed,

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[7]Legal scholars on all sides of the abortion issue have recognized that *Roe* does not address the killing of partly-born children. *See, e.g.*, Letter of Nov. 6, 1995 from Harvard Law Professor Laurence Tribe to Senators Barbara Boxer and Edward Kennedy, at 2 (stating that the Supreme Court "has never directly addressed a law quite like [the Partial-Birth Abortion Ban Act]"), quoted in 145 Cong. Rec. S12990 (Oct. 21, 1999); *The Origins and Scope of Roe v. Wade: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. (April 22, 1996) (testimony of Harvard Law Professor Mary Ann Glendon) (stating that "*Roe* says nothing about the killing of a baby during delivery"). In a joint letter to members of the United States Senate, over 60 law professors, conceding that "we are of different minds on various aspects of the abortion issue," wrote that "we are unanimous in concluding that such a ban [on partial birth abortions] is constitutional," and that such a ban falls "entirely outside the legal framework established in *Roe v. Wade* and *Planned Parenthood v. Casey*." Letter of May 8, 1997, to U.S. Senators, signed by 63 Professors of Law, reprinted at 143 Cong. Rec. S4706 (May 20, 1997). *See also* H.R. Rep. No. 105-24, at 15 (1997) (stating that "the Court has never addressed the constitutional status of those who are in the process of being born").

[8]Most state laws that ban such killing refer to it as "partial birth abortion." Ala. Code §§ 26-23-1 to 26-23-6; Alaska Stat. § 18-16-050; Ariz. Rev. Stat. § 13-3603.01; Ark. Code Ann. § 5-61-201 to 5-61-204; Fl. Stat. §§ 390.011, 390.0111(5); Ga. Code Ann. § 16-12-144; Idaho Code § 18-613; Ill. Comp. Stat. ch. 720, §§ 513/1 to 513/99; Ind. Code §§ 16-18-2-267.5, 16-34-2-1(b), 16-34-2-7(d); Iowa Code § 707.8A; Kan. Stat. Ann. § 65-6721; Ky. Rev. Stat. Ann. §§ 311.595(3), 311.720(7), 311-765, 311-990(11); La. Rev. Stat. Ann. § 1299.35.16; Mich. Comp. Laws §§ 333.17016, 333.17516; Miss. Code Ann. §§ 41-41-71 to 41-41-73; Mont. Code Ann. §§ 50-20-102(2)(e), 50-20-401; Neb. Rev. Stat. §§ 28-326(9), 28-328, 71-148(15); N.J. Stat. Ann. §§ 2A:65A-5 to 2A:65A-7; Ok. Stat. tit. 21, § 684; R.I. Gen. Laws §§ 23-4.12-1 to 23-4.12-6; S.C. Code Ann. § 44-41-85; S.D. Codified Laws §§ 34-23A-27 to 34-23A-32; Tenn. Code Ann. § 39-15-209; Utah Code Ann. § 76-7-310.5; Va. Code Ann. § 18.2-74.2; W.Va. Code §§ 33-42-3, 33-42-8; Wis. Stat. §§ 895.038, 940.16.

Other States use another term, such as "infanticide" or "feticide," in addition to, or in lieu of, partial birth abortion. Mo. Rev. Stat. § 565.300 (using the term "infanticide" to refer to the killing of a fully- or partly-born infant); La. Rev. Stat. Ann. § 32.9 (using the term "feticide" as designation of subpart, "partial birth abortion" as name of procedure); N.D. Cent. Code §§ 14-02.6-01 to 14-02.6-03 (making it unlawful to "intentionally cause[ ] the death of a living intact fetus while that living intact fetus is partially born," but using the term "partial birth abortion" as designation of chapter). The procedure is sometimes referred to as dilation and extraction (D&X), or intact dilation and evacuation (intact D&E).

Its name does not change what it is. The prohibited conduct is a new form of killing that takes place when a child is inches from full delivery, unlike any other procedure considered in this Court's abortion decisions. The Nebraska Legislature called it "partial birth abortion," as, for the sake of convenience, will we.

[9]Martin Haskell, "Dilation and Extraction for Late Second Trimester Abortion" (1992), reprinted in 139 Cong. Rec. E1092, 1993 WL 135664 (Apr. 28, 1993), and *Partial-Birth Abortion: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*,

Casey strengthens the case for upholding the Nebraska statute. Seven justices in *Casey* voted either to overrule *Roe*, 505 U.S. at 944 (Rehnquist, C.J., White, Scalia, and Thomas, JJ.), or to reaffirm its "essential holding" based on *stare decisis* and "principles of institutional integrity." *Id.* at 845-46 (O'Connor, Kennedy, and Souter, JJ.). The killing of partly-born children, however, is entirely new from the standpoint of both medicine and law. The procedure was announced as an "innovation" in a paper presented by Dr. Martin Haskell to the National Abortion Federation Risk Management Seminar in September 1992.[9] The abortion industry initially denied that this procedure

ever happened, then admitted that it happened, though rarely, and finally argued (as in this case) that it is constitutionally protected.[10]

Because of its novelty, no settled expectations have arisen concerning it. No member of this Court -- in *Roe*, *Casey*, or any other case -- has ever expressed an intent to apply *Roe* to partly-born children. Because the Court comes to the question for the first time, *stare decisis* does not apply. Similarly, "principles of institutional integrity" (*Casey*, 505 U.S. at 845) are not threatened by refusing to expand *Roe* to invalidate laws like Nebraska's, for neither the Constitution nor the Court's precedents restrict or even address the power of states to prohibit the killing of partly-born children.

A fresh examination of the question shows that the challenged Nebraska statute easily passes constitutional muster. The prohibited conduct clearly fails to satisfy the two tests for substantive due process protection that this Court reiterated just three Terms ago in *Washington v. Glucksberg*, 521 U.S. 702 (1997).

First, it is patently absurd to contend that killing a partly-born child is "deeply rooted in this Nation's history and

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104th Cong. 15-21 (June 15, 1995).

[10] *See, e.g.*, H.R. Rep. No. 105-24, at 5 (1997) (opponents of federal ban "argue[d] that the partial-birth abortion method does not exist," and then claimed that the procedure was "used rarely"); Diane M. Gianelli, "Shock-Tactic Ads Target Late-Term Abortion Procedure," Am. Med. News at 3 (July 5, 1993) (quoting National Abortion Federation claims that the unborn child is "dead 24 hours before the ... procedure is undertaken"), reprinted in *Partial-Birth Abortion: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. 9-11 (June 15, 1995).

tradition," as would be necessary to render it subject to constitutional protection. *Glucksberg*, 521 U.S. at 720-21. No state has ever approved the intentional killing of partly-born children. Indeed, news of this procedure produced near-universal shock among the Nation's policy makers and the public. There is nothing to suggest that the American public or the citizens of Nebraska failed to understand, or were insensitive to, the Nation's history and traditions when they acted through their elected representatives to ban such conduct.

Second, when subject to the "careful" and "precise" description mandated by *Glucksberg*, 521 U.S. at 721-23, it is apparent that the conduct Nebraska prohibits -- whether labeled "abortion" or "infanticide" -- cannot fairly be swept into the category of abortions to which this Court has given constitutional protection. In the first place, the statute does not impede the decision whether to terminate a pregnancy by abortion. Second, the prohibited conduct goes substantially further than, and differs in important respects from, the destruction of children *in utero* that the Court considered in *Roe* and *Casey*. The child is far closer to complete delivery; it has partly emerged from the mother's body; indeed, delivery is all but complete.[11]

The state also has a "legitimate moral interest" in prohibiting the killing of *partly*-born children. *Planned Parenthood v. Doyle*, 162 F.3d 463, 477 (7th Cir. 1998) (Manion, J., dissenting), *vacated*, 195 F.3d 857 (7th Cir. 1999).

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[11] The child's near complete delivery is illustrated by sketches of breech delivery and partial birth abortion reprinted in the Congressional record. *See The Partial-Birth Abortion Ban Act of 1995: Hearing Before the Senate Comm. on the Judiciary*, 104th Cong. 85-94 (Nov. 17, 1995); *Partial-Birth Abortion: The Truth: Joint Hearing Before the Senate Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 105th Cong. 56 (March 11, 1997).

That interest is not vitiated by the existence of equally gruesome methods of killing *wholly unborn* children to which this Court has accorded constitutional protection.[12] *Id.* To say there is no "moral difference" between abortion procedures the Court has deemed constitutionally protected, on the one hand, and the killing of partly-born children on the other, *Doyle*, 162 F.3d at 470, or that there is "[n]o reason of policy or morality" to permit one and forbid the other, *Hope Clinic v. Ryan*, 195 F.3d 857, 879 (7th Cir. 1999) (Posner, C.J., dissenting), *pet. for cert. filed*, Nos. 99-1152, 99-1156, 99-1177 (U.S. Jan. 10 and 14, 2000), is to displace without constitutional warrant a legitimate legislative judgment of the people of Nebraska. *Doyle*, 162 F.3d at 477 (Manion, J., dissenting) ("the court [of appeals] overextends when it concludes that there is no moral difference between partial birth abortion and other abortion procedures.... That is a decision for Wisconsin to make").[13]

Nebraska's moral interest is not only "legitimate," but extraordinarily compelling.[14] What is at stake in this case is the

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[12]By analogy, while this Court has not declared capital punishment unconstitutional, it agreed earlier this Term to hear a Florida case involving a prisoner's Eighth Amendment challenge to a sentence of death by electrocution, *Bryan v. Moore*, 120 S.Ct. 394 (1999) (granting writ of certiorari), later dismissed when Florida amended its law to permit death by other means. *Bryan v. Moore*, 120 S.Ct. 1003 (2000) (dismissing writ of certiorari as improvidently granted).

[13]Whether procedures other than partial birth abortion may constitutionally be regulated by the Nebraska Legislature is irrelevant to the question whether it may regulate, or prohibit, partial birth abortion. A legislature "may take one step at a time," *Williamson v. Lee Optical*, 348 U.S. 483, 489 (1955), "select[ing] one phase of one field and apply[ing] a remedy there, neglecting the others." *Id.*

[14]Physicians have noted the "iron[y] that the pain management practiced for an intact D&X on a human fetus would not meet federal

life of a child. Few interests could be more deserving of the law's protection. Few things could be more suggestive of who we are as a Nation than our efforts to protect the innocent lives of children, or our failure to do so. The Constitution does not forbid such legislative efforts even when the child is not fully born. Surely this Court would not conclude, for example, that a child fully born save for a foot or hand is beyond the legitimate power of the legislature to protect. By the same token, the Constitution cannot fairly be read to forbid the Nebraska Legislature to prohibit the killing of children who are substantially born. Constitutional abortion does not embrace such conduct.

II. Consistent With *Casey*, the Nebraska Statute Serves the State's Legitimate Interests in Protecting Human Life and Regulating, and Preserving the Integrity and Ethics of, the Medical Profession.

A. Protecting Human Life

Decisions of this Court acknowledge the state's paramount and unqualified interest in protecting human life. Twice in the last decade the Court has given significant recognition to that interest, first when it upheld a state's heightened evidentiary standard for decisions to discontinue life-sustaining treatment, *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), and again when it upheld state

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standards for the humane care of animals used in medical research." Sprang & Neerhof, *supra* note 2, at 745. Quoting prior testimony of a professor of pediatrics and anesthesia, one witness informed the Nebraska Legislature that a partial birth abortion, "if it was done on an animal ..., would not make it through the institutional review process. The animal would be more protected than the child is." Nebraska Committee on Judiciary, Hearing Transcript at 67, Hearing on LB 23, 167 & 217 (Feb. 12, 1997).

laws prohibiting physician-assisted suicide. *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).

Seven justices in Casey acknowledged that a state's interest in protecting human life gives it the power to regulate abortion beyond what the Court had allowed in the years between *Roe* and *Casey*. The plurality opinion in *Casey* was an explicit attempt to correct post-*Roe* cases that the plurality said had given inadequate weight to the state's interest in protecting life. 505 U.S. at 846, 870-76. If, as is true under *Casey*, states are not required to remain uninterested in protecting the life of a child *in utero*, they certainly have the power to protect children whose emergence from the mother is nearly complete.

Furthermore, the state may reasonably conclude that killing a partly-born child is a significant step toward, if it does not constitute, a form of infanticide, and constitutionally may act to prevent such conduct as a bulwark against outright infanticide. Credible reports of outright infanticide have surfaced that give legitimacy to these concerns,[15] and Nebraska legislators were aware of (and alarmed by) the resemblance between partial birth abortion and outright infanticide.[16]

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[15] *E.g.*, Tim Swarens, "Live Birth Shocked a Nurse," *The Indianapolis Star* (Dec. 3, 1999) (setting out the report of an employee of a company that collects fetal tissue that a physician "killed the babies after they were born"); James Tunstead Burtchaell, RACHEL WEEPING 288 (1982) (doctors charged with manslaughter following infant deaths allegedly caused by strangulation or failure to provide care following birth). *See* Brief *Amicus Curiae* of Family Research Council (documenting other reported instances of infanticide).

[16] Nebraska Senator David Maurstad stated: "If there is any action that comes closer to infanticide, I don't want to know of it.... I propose to the [Judiciary] [C]ommittee that an abortion procedure providing for the near

Because killing a *fully-born* infant would indisputably rob the newborn child of the natural and constitutional right of every human being to live, the State is warranted in erecting the highest possible fence to prevent it.[17] There is nothing in the text or values of the Constitution to prevent Nebraska from doing this. The State may draw a hard line between abortion that this Court has held to be constitutionally protected on the one hand, and conduct that approaches or constitutes infanticide on the other. *Cf. Quill*, 521 U.S. at 800-08 (holding that state legislatures constitutionally may draw a bright line between withdrawing treatment and assisting a suicide).

Whether or not partly-born children are constitutional persons -- a question this Court declined to consider in its order granting certiorari in this case -- need not be resolved for this Court to conclude that the Constitution permits States to forbid the intentional destruction of partly-born children. Put another

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birth of a child followed by its extinction should not be permitted in the state of Nebraska." Nebraska Committee on Judiciary, Hearing Transcript at 48, Hearing on LB 23, 167 & 217 (Feb. 12, 1997). Nebraska Senator Kate Witek stated that "the child subjected to a partial birth abortion is merely inches away from the full protection of homicide laws in all 50 states." *Id.* at 50. A committee witness agreed that the conduct at issue is "four-fifths infanticide." *Id.* at 65. Similar concerns were expressed during the floor debates in the Nebraska Legislature. *E.g.*, Transcript of Proceedings of the Nebraska Legislature at 3958 (Apr. 11, 1997) ("What LB 23 does prevent is near infanticide"); *id.* at 6766 (May 14, 1997) (the procedure "is much too close to infanticide").

[17] Disturbingly, arguments in favor of the direct killing of newborn infants have been made (and are being taken seriously) in some academic circles. *E.g.*, Peter Singer, RETHINKING LIFE AND DEATH: THE COLLAPSE OF OUR TRADITIONAL ETHICS 128-31, 210-17 (1994); Peter Singer, "Sanctity of Life or Quality of Life?," 72 Pediatrics 128-29 (July 1983); Michael Tooley, ABORTION AND INFANTICIDE (1983); H. Tristram Engelhardt, "Ethical Issues in Aiding the Death of Young Children," in Marvin Kohl (ed.), BENEFICENT EUTHANASIA 188 (1975).

way, the Constitution does not *require* States to treat partly-born children as non-persons. At that stage when the child is neither fully in the womb nor fully delivered, there is nothing in the Constitution or in this Court's decisions that would rob states of the discretion to vindicate their strong interest in protecting vulnerable human life.

B. Protecting the Integrity and Ethics of the Medical Profession

The state has "an interest in protecting the integrity and ethics of the medical profession." *Glucksberg*, 521 U.S. at 731; *see also Semler v. Oregon State Board of Dental Examiners*, 294 U.S. 608, 611-12 (1935).[18] The authority to license and regulate the practice of medicine is a "vital part of a state's police power." *Barsky v. Board of Regents*, 347 U.S. 442, 449 (1954). A licensed physician has no right to practice medicine according to his or her own unfettered judgment. *Whalen v. Roe*, 429 U.S. 589 (1977); *see also Lambert v. Yellowley*, 272 U.S. 581, 596 (1926) (observing that "there is no right to practice medicine which is not subordinate to the police power of the states").

The state's authority to regulate the medical profession does not evaporate once the subject turns to abortion. *Roe* itself recognized that the state may enact regulations to protect medical standards. *Roe v. Wade*, 410 U.S. at 155, *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 428-29 (1983). States may prohibit abortions by persons not licensed to practice medicine. *Mazurek v. Armstrong*, 520 U.S. 968

[18]This interest is one upon which courts frequently rely in resolving disputes about whether to provide or discontinue life-sustaining medical treatment. *Matter of Conroy*, 486 A.2d 1209, 1223 (N.J. 1985), and cases cited therein.

(1997); *Connecticut v. Menillo*, 423 U.S. 9 (1975). States may require that women seeking an abortion be given certain information by their physician, *Casey*, 505 U.S. at 881-87, as is the case with any surgical procedure.

However, a practice that borders on, if it does not constitute, infanticide threatens dramatically to reconstitute the ethic underlying medicine. Killing a partly-born child contradicts the duty of the physician as healer. Physicians must not be killers. *Glucksberg* and *Quill* both upheld this basis for the state's regulatory authority. *Glucksberg*, 521 U.S. at 731; *Quill*, 521 U.S. at 794. A June 1997 fact sheet issued by the American Medical Association's ("AMA") Board of Trustees states that partial birth abortion "is ethically wrong."[19] AMA President Daniel H. Johnson, Jr., M.D., wrote that "the partial delivery of a living fetus for the purpose of killing it outside the womb is ethically offensive to most Americans and physicians." *The New York Times*, May 26, 1997 (letter to the editor). Former Surgeon General C. Everett Koop agreed, concluding that partial birth abortion "cannot and should not be considered 'medicine' by any stretch of the imagination." Letter of June 13, 1997, from C. Everett Koop, M.D., to Mark A. Levine, Chairman, Reference Committee B, American Medical Association.

Past experience suggests that if physicians were given a license to kill partly-born children, it would have a corrosive effect on medicine and medical ethics. It is instructive on this

[19]The AMA fact sheet states: "The procedure is ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed *outside* the womb. The 'partial birth' gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body." AMA Board of Trustees Fact Sheet on H.R. 1122, at 1 (June 1997) (original emphasis).

point to consider how the abortion license has led to attempts to coerce physicians and hospitals to perform abortions over their moral and ethical objections. Not long ago, for example, the Accreditation Council for Graduate Medical Education ("ACGME") proposed a change in accreditation standards to require teaching hospitals to provide abortion training in their obstetrics and gynecology residency programs. Ultimately Congress intervened to ensure that this requirement will not be used to deny accreditation or federal grants to programs that decline to perform abortions. 42 U.S.C. § 238n. Drawing lessons from this episode, one physician suggested to Congress that the practice of partial birth abortion, if allowed, will in the same way "undoubtedly be used to coerce individuals and institutions to participate in procedures that violate their moral conscience." *Partial-Birth Abortion: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. 39 (June 15, 1995) (statement of Pamela Smith, M.D.). The challenged Nebraska statute thus avoids the kind of ethical dilemma in which conscientious physicians and medical educators would likely be placed if a state license to practice medicine were construed to encompass the killing of partly-born children.

Even if Nebraska had prohibited a particular *intra-uterine* abortion procedure, which is not the case here, its prohibition would pass constitutional muster under this Court's precedents. Only once in its history has this Court struck down a ban on a particular method of abortion. *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976). The procedure was saline amniocentesis. Citing testimony that 68% to 80% of all abortions after the first trimester were at that time done through saline amniocentesis, the *Danforth* Court concluded that a ban on the procedure forced women to terminate their pregnancy "by methods more dangerous to [their] health than the method outlawed." 428 U.S. at 77-79.

The distance between the Court's description of saline amniocentesis in 1976 and the medical profession's description of partial birth abortion today is remarkable. A "group of over 400 obstetrician-gynecologists and maternal-fetal specialists have unequivocally stated, 'partial-birth abortion is never medically indicated to protect a woman's health or her fertility. In fact, the opposite is true: The procedure can pose a significant and immediate threat to both the pregnant woman's health and her fertility.'" H.R. Rep. No. 105-24, at 15 (1997), quoting Nancy Romer, M.D., Pamela Smith, M.D., Curtis Cook, M.D., & Joseph DeCook, M.D., "Partial Birth Abortion is Bad Medicine," *Wall Street Journal*, Sept. 19, 1996.

The AMA "could not find *any* identified circumstance in which the [partial birth abortion] procedure was the only safe and effective abortion method." *New York Times*, May 26, 1997 (letter from AMA President Daniel H. Johnson, Jr., M.D., to the editor) (emphasis added). Likewise, a "select panel convened by the American College of Obstetricians and Gynecologists could identify *no* circumstances under which this procedure ... would be the only option to save the life or preserve the health of the woman." American College of Obstetricians and Gynecologists ("ACOG"), Statement of Policy (approved by the Executive Board Jan. 12, 1997, and distributed to ACOG chairs) (emphasis added).

The Nebraska Legislature was informed by a coalition of physicians that "the partial birth [abortion] procedure is never medically necessary." Nebraska Committee on Judiciary, Hearing Transcript at 50, Hearing on LB 23, 167 & 217 (Feb. 12, 1997) (as reported by Senator Kate Witek); *see id.* at 65 ("our former Surgeon General, Dr. C. Everett Koop, and hundreds of other specialists have attested to the fact that 'partial birth abortion is never medically necessary to protect a mother's health or future fertility ... [and that] this procedure can

pose a significant threat to the mother's immediate health and future fertility'").[20]

What abortion practitioners themselves have had to say about partial birth abortion is even more damning. "I would dispute any statement that this is the safest procedure to use," says Warren Hern, author of the nation's most widely used textbook on abortion. Diane M. Gianelli, "Outlawing Abortion Method: Veto-Proof Majority in House Votes to Prohibit Late-Term Procedure," *Am. Med. News* (Nov. 20, 1995) at 3, quoted in H.R. Rep. No. 105-24, at 15 (1997). A Dayton physician who had performed more than 700 partial birth abortions said that of the abortions he performs in the 20- to 24-week range, "probably 20% are for genetic reasons, and the other 80% are purely elective." Diane Gianelli, "Bill Banning Partial-Birth Abortion Goes to Clinton," *Am. Med. News* (Apr. 15, 1996) at 9-10. Claims that partial birth abortion may be necessary for health reasons are also belied by the admission of the very abortion clinics and doctors challenging partial birth abortion bans that they never or rarely perform such abortions. *Richmond Medical Center v. Gilmore*, 144 F.3d 326, 327 (4th Cir. 1998) (granting stay); *Planned Parenthood v. Doyle*, 9 F.Supp.2d 1033, 1045 (W.D. Wis. 1998) (physician challenging Wisconsin's ban had performed 60,000 abortions, but only "one or two" partial birth abortions each year), *rev'd*, 162 F.3d 463 (7th Cir. 1998).

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[20]Congress heard similar testimony. One physician testified that "there are absolutely no obstetrical situations encountered in this country" which would require a partial birth abortion "to preserve the life or health of the mother." *The Partial-Birth Abortion Ban Act of 1995: Hearing Before the Senate Comm. on the Judiciary*, 104th Cong. 82 (Nov. 17, 1995) (statement of Pamela Smith, M.D.). Another noted that the procedure "offers no advantage in safety" over other methods of abortion. *Id.* at 112 (statement of Nancy G. Romer, M.D.).

Nearly every aspect of the physician-patient relationship is touched by regulation, from training and licensure to a host of prescribed duties, including informed consent, restrictions on advertising, maintenance of patient confidentiality, and so on. Abortion, let alone the killing of partly-born children, is not exempt from such scrutiny and regulation.

It should be recalled that abortion is *a surgical procedure* with consequent medical risks and complications. The Nebraska Legislature heard testimony about these risks from an obstetrician-gynecologist and fellow of the American College of Obstetricians and Gynecologists:

> I think it's important to realize that this procedure asks of us as doctors to do two, at least two, possibly as many as three very, very risky procedures. One is the dilation of the cervix itself manually before it is time for that to occur on its own and that runs a woman's risk up for preterm labor in the future. Also the instrumentation, putting sharp instruments into a woman's uterus blindly runs the risk of uterine perforation. And the very procedure of reaching into a woman's uterus, turning the baby from a head first position to a feet first position is literally ... forbidden by the Williams Obstetrics and Gynecology textbook as being entirely too risky for many different medical complications that occur because of that.

Nebraska Committee on Judiciary, Hearing Transcript at 64, Hearing on LB 23, 167 & 217 (Feb. 12, 1997) (testimony of Paul Hayes, M.D.). *See also* Sprang and Neerhof, *supra* note 2, at 744-45.

Given the rapidity of change in medicine and medical technology, the Court should be especially reluctant to substitute its own judgment for that of the legislature on these questions. The "regulation of the practice of medicine, like regulation of other professions" is a "matter peculiarly within the competence of legislatures...." *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 802 (1986) (White, J., dissenting), *overruled in part, Planned Parenthood v. Casey*, 505 U.S. at 870. Legislatures are in a better position than courts to collect information and respond to changes in medical practice and technology. As individual members of this Court have observed, the Court does not sit, and has expressed no desire to sit, as the Nation's "*ex officio* medical board with powers to approve or disapprove medical and operative practices and standards throughout the United States." *Webster v. Reproductive Health Services*, 492 U.S. 490, 519 (1989) (plurality opinion), *quoting Planned Parenthood v. Danforth*, 428 U.S. 52, 99 (1976) (White, J., concurring in the judgment in part, dissenting in part).[21]

We urge the Court to uphold the Nebraska statute.

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[21]The seemingly endless monitoring and fact-finding that would be necessary were the courts to assume such an inherently legislative function is suggested by Judge Posner's dissent in *Hope Clinic v. Ryan*, 195 F.3d 857, 876 (7th Cir. 1999). He concedes that today the state "may be right" that partial birth abortion is "*never* required to preserve a woman's health" (original emphasis), but speculates that "[t]omorrow, studies may show" otherwise, *id.* at 880, thus inviting the very sort of continuing judicial supervision that is inappropriate to constitutional adjudication.

CONCLUSION

A majority of the American people decry the partial birth abortion procedure. Their response is based on a shared moral sense, one rooted in an understanding of themselves and the sort of society they wish to build for themselves. The reasonable and democratically expressed judgment of ordinary American citizens to prohibit what can only be described as a ghastly practice unworthy of any civilized Nation should not lightly be cast aside. Indeed, the Constitution would seem to require great deference to that judgment.

The *Casey* plurality expressed reservations about how they would have decided the abortion question if that case had been one of first impression. Unlike *Casey*, this *is* a case of first impression. We urge the Court to consider carefully both the conduct involved and the important role of legislatures in drawing conclusions about it. Clarity about what this Court has done in the past and faithfulness to the Constitution require that the Nebraska statute be upheld.

The judgment of the Eighth Circuit should be reversed.

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In The
SUPREME COURT OF THE UNITED STATES

DONALD STENBERG,
Petitioner,

v.

LEROY CARHART,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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MOTION FOR LEAVE TO FILE BRIEF AND BRIEF *AMICUS CURIAE* OF THE RUTHERFORD INSTITUTE IN SUPPORT OF PETITIONER

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the Eighth Circuit's adoption of a broad unconstitutional reading of Nebraska's ban on partial-birth abortion, which directly conflicts with the narrower constitutional construction of similar statutes by the Seventh Circuit Court of Appeals and that of the State officials charged with enforcement of the statute, violates fundamental rules of statutory construction and basic principles of federalism in contradiction of the clear direction of this Court in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989)?

2. Whether the Eighth Circuit misapplied this Court's instructions in *Planned Parenthood v. Casey*, 505 U.S. 83 (1992) by finding that a law banning cruel and unusual methods of killing a partially-born child is an "undue burden" on the right to abortion?

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE IN SUPPORT OF PETITIONER

The Rutherford Institute hereby respectfully moves the Court for leave to file the following brief *amicus curiae* in this case. The consent of counsel for the parties was requested and refused.

The Rutherford Institute is an international, non-profit civil liberties organization with offices in Charlottesville, Virginia and internationally. The Institute, founded in 1982 by its President, John W. Whitehead, educates and litigates on behalf of constitutional and civil liberties. Attorneys affiliated with the Institute have filed petitions for writ of *certiorari* in the United States Supreme Court in more than two dozen cases, and *certiorari* has been accepted in two seminal First Amendment cases, *Frazee v. Dept. of Employment Sec.*, 489 U.S. 829 (1989) and *Arkansas Educational Television Comm'n. v. Forbes*, 523 U.S. 666 (1998). Institute attorneys have filed over three dozen *amicus curiae* briefs in the United States Supreme Court, including *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989) and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). The Institute has published educational materials and taught continuing legal education classes in this area as well.[1]

The Rutherford Institute has as one of its purposes fostering respect for the uniqueness and paramount worth of human life. These values are deeply rooted in America's common law constitutional tradition and its morality and values. Diminishing the value and

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1 John W. Whitehead has published several books, numerous articles and two amicus briefs on abortion issues. *See, e.g.,. Webster v. Reproductive Health Services*, 492 U.S. 490 (1989) and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). The Institute also publishes informational pamphlets and briefs addressing abortion.

respect for life, including prenatal life, diminishes, in one form or another, the lives of all citizens. The Rutherford Institute believes that this case concerning the power of states to regulate abortion is important to constitutional jurisprudence and the growth and progress of the nation.

Beginning in 1985, *amicus curiae* undertook to extensively research the available medical and social literature to determine the extent to which the legalization of abortion had an adverse effect on the quality of life, the impact on the family, and its effect on health and social life. The relevant portions of that research are presented particularly as applied to the issue of partial birth abortion. The Rutherford Institute believes the expertise of its counsel will be of assistance to the Court in this case.

The Rutherford Institute is submitting a brief *amicus curiae* in support of the Petitioner. In light of the important issues being raised in this case, the Institute respectfully requests that its arguments be heard.

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TO THE HONORABLE CHIEF JUSTICE AND ASSOCIATE JUSTICES OF THE SUPREME COURT OF THE UNITED STATES:

STATEMENT OF *AMICUS CURIAE* INTEREST AND INTRODUCTION[2]

The Rutherford Institute is an international, non-profit civil liberties organization with offices in Charlottesville, Virginia and internationally. The Institute, founded in 1982 by its President, John W. Whitehead, educates and litigates on behalf of constitutional and civil liberties. Attorneys affiliated with the Institute have filed petitions for writ of *certiorari* in the United States Supreme Court in more than two dozen cases, and *certiorari* has been accepted in two seminal First Amendment cases, *Frazee v. Dept. of Employment Sec.*, 489 U.S. 829 (1989) and *Arkansas Educational Television Comm'n. v. Forbes*, 523 U.S. 666 (1998). Institute attorneys have filed over three dozen *amicus curiae* briefs in the United States Supreme Court, including *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989) and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). The Institute has published educational materials and taught continuing legal education classes in this area as well.

One of the purposes of The Rutherford Institute is to foster respect for the uniqueness and paramount worth of human life. These values are deeply rooted in America's common law constitutional tradition and its morality and values. Diminishing the value and respect for life, including prenatal life, diminishes, in one form or another, the lives of all citizens. The Rutherford Institute believes that this case concerning the power of states to regulate abortion is

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2 *Amicus curiae* The Rutherford Institute files this brief on Motion to the Court for leave to do so. Consent of counsel for the parties was sought and refused. Counsel for The Rutherford Institute authored this brief in its entirety. No person or entity, other than the Institute, its supporters, or its counsel, made a monetary contribution to the preparation or submission of this brief.

important to constitutional jurisprudence and the growth and progress of the nation.

Beginning in 1985, *amicus curiae* undertook to extensively research the available medical and social literature to determine the extent to which the legalization of abortion had an adverse effect on the quality of life, the impact on the family, and its effect on health and social life. The relevant portions of that research are presented particularly as applied to the issue of partial birth abortion. The Rutherford Institute believes the expertise of its counsel will be of assistance to the Court in this case.

SUMMARY OF ARGUMENTS

There is a public interest as well as a state interest in legislating against immoral acts and recognizing the moral status of the unborn child. Recognition of moral status does not require that legal personhood be established. It is sufficient if the existence of a living entity is recognized and that unjust or immoral acts may be committed against this entity. To a significant degree, the moral status or the social standing of the unborn becomes obvious when viewed in light of the moral outrage exhibited when Nebraskans learned of the cruel manner of the destruction by partial birth abortion. Moral status requires that the existence of actual life be acknowledged, not simply "potential life." Nor can the perceived therapeutic needs of others relegate the unborn child to a non-entity.

In the state of Nebraska, animals are protected from cruelty. The manner of the death of an animal is also regulated by the state. No one claims that an animal is a person or a human being. In addition to the enactment prohibiting partial birth abortion, the state legislature of Nebraska, by specific legislative findings and declared legislative purpose, has deplored the destruction of unborn human lives. However, the courts below have failed to take into account these legislatively mandated and constitutionally acceptable purposes.

Nebraska also has an interest in the moral status of the unborn

child because pregnant women who seek partial birth abortions do not protect this interest. These women are impaired in their decision-making because of a manipulation of their thought process prior to undergoing partial birth abortion. Most importantly, women are not given accurate information about the specific nature of the partial birth abortion prior to undergoing the procedure. Women who are likely to undergo a partial birth abortion are a special population who have been shown to have tendencies which increase the likelihood of undergoing this type of procedure. These tendencies include denial, low self-esteem and identity conflicts, immaturity, lack of social and economic resources as well as an inability to receive offers of assistance.

Most medical doctors and medical societies do not recognize the moral status of the unborn child. This occurs despite the fact that workers in abortion facilities frequently find that abortions at the late stage of pregnancy required for partial birth abortions are repugnant. In addition, doctors who perform partial birth abortions are well compensated for their services and may act as no more than a technician without consideration of the moral status of the unborn child. Similarly, medical societies, although recognizing the fetus as a patient for some purposes, abandon the unborn child to the claims of the pregnant woman.

ARGUMENT

I. There Is an Important Public and State Interest in the Moral Status of the Unborn Child as Intended by the Nebraska Law Banning Partial Birth Abortions.

A. The Unborn Child Is Entitled to a Recognized Moral Status.

Recognizing the moral status of the unborn child in the context of partial birth abortion does not require that legal personhood be established. What constitutes moral status is:

(1) the recognition that there is the existence of a living entity, and
(2) immoral or unjust acts may be committed against this living entity.

Status refers to a condition or social standing. To a significant degree, moral status or social standing has been bestowed upon unborn children by those who were morally outraged when they learned of the cruel manner of their destruction by the partial birth abortion procedure. Public officials used a variety of words or phrases to describe their feelings about partial birth abortion including "barbaric", "shocks the conscience" or "unfit for a civil society."[3] Public opinion polls have found that a substantial majority of those polled were opposed to partial birth abortion, and 30 states have passed legislation to ban the practice, frequently by large margins. Yet many of the laws were enjoined by the courts, including the Nebraska ban on partial birth abortion.

B. Unborn Children Are Not "Potential Life" Subject to the "Therapeutic" Considerations of

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3 Repugnance for abortion has been advanced as a possible intuitive response to resolution of the polarization over abortion. The reason is because it was observed that abortion protesters frequently carried signs showing abortions in later stages of pregnancy. Also, repugnance for abortion at later stages is frequently found among abortion facility personnel. *See, e.g.* Kaltreider, Goldsmith & Margolis, *The Impact of Mid Trimester Abortion Techniques on Patients and Staff*, 135 Am. J. Obstet. Gynecol. 235 (1979), Hern, *What about us? Staff Reactions to D & E*, 15 Adv. Planned Parenthood 3 (1980). Repugnance may be rooted in an empathic kinship with one another that is the source of what is precious and caring in human relationships when it is present - and all that is horrible and brutal when it is absent. Judges, *Hard Choices, Lost Voices. How the Abortion Conflict Has Divided America, Distorted Constitutional Rights, and Damaged the Courts*, 287 (1993).

Others.

In *Planned Parenthood v. Casey*, 505 U.S. 833, 876 (1992) the plurality opinion stated that the "state has a substantial interest in potential life." It is clear that actual life is being destroyed when arms are moving and feet are kicking as the unborn child is being killed in the partial birth abortion process. If one has only a potential life, it becomes virtually impossible to determine what obligations there might be to this potential life because these obligations only exist in the future. How can one be cruel, kind, just or unjust, protective or destructive to someone or some thing with such a vague, amorphous status?

The paramount emphasis on "therapeutic" abortion for the perceived benefit of the pregnant woman also plays an important role in denying the moral status of the unborn child. Sociologist Christopher Lasch has noted, "The contemporary climate is therapeutic, not religious. People today hunger not for personal salvation.. . but for the feeling, the momentary illusion of personal well-being, health,[4] and psychic security." Lasch, *The Culture of Narcissism* (1979). Terms such as free will, guilt, good and evil have no place in the therapeutic model. Kittrie, *The Right to Be Different, Characteristics of the Therapeutic State*, 39 (1971). In the therapeutic model, people are diseased, ill, or socially maladjusted, or perhaps immature, unbalanced or stressed. In the therapeutic model it is the doctor or scientist or therapist who is presumed to know what is best. One author calls it "therapeutic relentlessness." Hamburger,

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4 An editorial in the American Journal of Public Health, although acknowledging that morality and other values may come into play to a limited degree, said that health professionals are obligated to put health first, to do so by respecting the best available scientific evidence, and to be frank when putting aside evidence of other considerations, be they moral, religious, economic, or simple expedience. Susser, *Induced Abortion and Health as a Value*, 82 American Journal of Public Health 1323 (1992).

The Power and the Frailty: The Future of Medicine and the Future of Man, 83 (1973).

Another refers to this therapeutic model as a "modern form of torture, combining benevolence, indifference, and technological wizardry." Starr, *The Social Transformation of American Medicine*, 390 (1982). There is no place in the therapeutic model for any entity with moral status - least of all an unborn child.

C. Animals Are Protected from Cruelty in the Manner of Their Death.

In Nebraska, animals have more status than unborn children. No one claims these animals are persons or human beings. Animals are protected from cruel and inhumane treatment under existing Nebraska law prohibiting cruelty to animals. *See* Section 28-1008 through §28-1016, Rev. Stat. Neb., Reissue of 1995. Under the definition of terms section of that statute, cruelly mistreating means to knowingly and intentionally kill, maim, disfigure, torture, beat, mutilate, burn, scald, or otherwise inflict harm upon any animal. (Section 28-1008 (3)). Violations of the law are criminal acts. (Section 28-1009). Further, the law prohibiting cruelty to animals also regulates the manner of death of an animal. (Section 28-1008 (5)). If the state of Nebraska has the power to prevent cruelty to animals, including the manner of death, it certainly has the power to enact a law regulating the manner of death of unborn children, especially where the prohibited technique involves a particularly gruesome method of abortion.

D. The Opinion of the Federal District Court Sets Forth a Form of Killing Using the Partial Birth Abortion Method Which Is Within the Power of the State to Prohibit.

The partial birth abortion procedure or intact D & E or D & X described in the Federal District Court opinion in *Carhart v. Stenberg*, 972 F.Supp 507 (D.Neb 1997) sets forth a form of killing

performed in a clinical setting. According to the opinion, these killings are attempted or completed after the 15th week of gestation and not later than the 20th week of gestation. The procedure includes draining the amniotic fluid before beginning the evacuation procedure. The Respondent then attempts to grasp and divide the umbilical cord of the fetus, which transports arterial and venous blood between the fetus and the placenta. If he divides the cord, the fetus will usually die within 6 to 10 minutes. If he succeeds in dividing the umbilical cord, he does not wait for fetal death to occur before continuing the procedure.

When the fetus is presented feet first, the Respondent uses forceps to pull the feet of the living fetus from the uterus into the vaginal canal. He then pulls the remainder of the fetus, except the head, into the vaginal cavity to a point where the base of the fetal skull is lodged in the uterine side of the cervical canal. At that point, the size of the head will not permit him to pull it through the cervical canal into the vaginal cavity. To decompress the fetal skull and evacuate the contents in order to pull it through the cervical canal, the Respondent uses an instrument to either tear or perforate the skull to allow insertion of a cannula and removal of the brain and cranial fluid and tissue. If more convenient, he will crush the skull rather than pierce it in order to reduce the size of the skull. Brain death occurs sometime during this two to three second "reduction" procedure, but fetal heart function may continue for several minutes after the fetus's skull is decompressed. *Id.* at 514. Respondent testified that, in 1996, he removed approximately 20 fetuses completely intact and alive. The record indicates that this act was done deliberately and intentionally to cause the death of the fetus. This behavior is within the power of the state to regulate.

E. The Courts below Have Failed to Follow Established Principals of Decision-making and Recognize and Defer to Legislatively Mandated Purposes When They Relate to Abortion.

The state legislature of Nebraska has deplored the destruction

of unborn human lives by specific legislative findings and legislative declaration of purpose. Section 28-325. These legislative purposes specifically recognize and protect life in the womb and have been recognized by the state courts. In *Damos v. St. Pierre*, 402 So.2d 633 (La. 1981), parents were allowed to recover damages for a pre-natal injury to a fetus subsequently born dead. The court relied upon language in a statement of legislative purpose which stated that a person includes a human being from the moment of conception. In *Connor v. Monkem Co, Inc.*, 898 S.W.2d 89 (Mo. 1995), the Missouri Supreme Court held that non-viable unborn children may have wrongful death claims based on a legislative purpose which stated that legally protectable rights, privileges and immunities exist at the time of conception.

In other cases, state courts have recognized a cause of action for the wrongful death of unborn children based upon specific language in a wrongful death statute. In *Wiesrma v. Maple Leaf Farms*, 543 N.W.2d 787 (S.D. 1996), a non-viable fetus died after the mother contracted salmonella from the defendants. In interpreting a wrongful death statute that authorized a cause of action for the "death or injury of a person, including an unborn child," the South Dakota Supreme Court held that this applied to non-viable fetuses. In *Seef v. Sutkus*, 583 N.E. 2d 510 (Ill. 1991), an Illinois court recognized a fetus as a person under the state's wrongful death statute, which stated that the state of gestation of a human being shall not foreclose a cause of action. In Georgia, the crime of feticide was defined as the willful killing of a "quick" (or living) unborn child. A suit by the mother against the defendant for the homicide of an unborn child who was "quick" was allowed. *Porter v. Lassiter*, 87 S.E.2nd 100, (Ga. App. 1955). And in *Farley v. Sartin*, 466 S.E. 2d 522 (W. Va. 1995), a fetus of 18-22 weeks gestation had died in an automobile accident. The court held that the viability of a fetus was no longer a requirement for the wrongful death of a fetus. The court concluded there was no rational reason not to include non-viable fetuses, especially in light of statutory language that the wrongful death statute should be liberally construed.

In contrast, where there has been no legislative language specifically recognizing liability for the wrongful death of an unborn child, courts have refused to do so without such inclusive language. In *Humes v. Clinton*, 792 P.2d 1032 (Kan. 1990), a suit was brought by the parents for the wrongful death of a fetus after the mother underwent a therapeutic abortion after complications due to the use of an IUD. The court dismissed the wrongful death suit stating that if such a cause of action was to be created, it must be done by the legislature. Again, *Giardina v. Bennett*, 545 A.2d 139 (N.J. 1988), the court narrowly interpreted the word "person" as not to include an unborn child. They held that the cause of action for wrongful death was the creature of statute, and since the legislature had not adopted specific language to include unborn children, there was no cause of action. In *Thilbert v. Milka*, 646 N.E.2d 1025 (Mass. 1995), a Massachusetts court refused to extend wrongful death protection to a 16 week old fetus where the fetus was stillborn and held that any extension of liability was properly left to the legislature.

Since the Nebraska legislature has recognized unborn children as alive and human, recognition of the moral status of the unborn child and the granting of protection from being killed by means of partial birth abortion will, at least to a limited degree, carry out the legislatively mandated enactments of the state.

F. States May Legislate Against Immoral Acts.

The practice of partial birth abortion is immoral, and states have a legitimate interest in prohibiting conduct deemed immoral. *Bowers v. Hardwick*, 478 U.S. 186, 196 (1986) (upholding a Georgia sodomy law in part because it was rationally related to "the presumed belief of a majority of the electorate in Georgia that homosexual sodomy is immoral and unacceptable."). States can also make immoral conduct a crime. *Milner v. Apfel*, 148 F3d. 812, 814 (7th Cir 1998) (stating that a traditional purpose of criminal punishment is to express moral condemnation of the criminal's acts.)

The federal district court in *Planned Parenthood of Wisconsin*

v. Doyle II., 44 F.Supp.2d 975, 983 (W.D. Wis. 1999) specifically held that the state of Wisconsin had a legitimate state interest in morality as applied to the D & X procedure. It stated:

> at the point that the child is just inches from being born the state has sufficient interest to regulate the manner of the child's death, regardless of whether the state is able to keep the child alive. Wisconsin has declared that such children are not to endure - and Wisconsin physicians are not to inflict - the gruesome death imposed in the D & X procedure ... because it is apparently beyond Wisconsin's power to eliminate ... other methods of abortion Wisconsin can eliminate this one method.

In *Planned Parenthood of Wisconsin v. Doyle I.*, 162 F.3d 463,477-479 (7th Cir 1998), Manion, J., dissenting, stated that "there is a legitimate moral interest in banning the D & X procedure, and that the state's interests in potential life, in regulating the practice of medicine, and in the moral underpinnings of state law are legitimate." All these state interests form a solid basis for the state enacting a law to ban D & X abortions. Although Judge Manion acknowledged that the law may not save any lives, he noted that, "these laws have certainly elevated the public's concern over the fate of the potential human lives that are exposed to abortion." *Id.* at 479.

II. The State Has an Interest in the Moral Status of the Unborn Child Because Pregnant Women Who Have Partial Birth Abortions Do Not Protect this Interest.

A. Pregnant Women Who Seek Partial Birth Abortions Are Impaired in Their Decision-making Because of the Manipulation of Their Mental and Emotional State and Their Lack of Informed Consent.

Late term, mechanically induced abortion procedures such as dilatation and extraction (D & E) or partial birth abortion depend on a state of denial by the woman at the time the abortion is performed.

This is accomplished by administration of general anesthesia or sedation[5] to the woman to insure that she does not know or see exactly what is occurring. According to the AMA report, D & E procedures in the mid to late second trimester usually are performed with local anesthesia, using sedation and a paracervical block. *Carhart v. Stenberg*, 972 F. Supp. 507 at 512. The sedation, in particular, alters the thought processes of the woman to the point where she would cannot accurately perceive what is occurring[6] and cannot scream out in protest or come to the aid of the unborn child whose life is about to be destroyed if she wished to do so. Once her consciousness is altered, it is the medical doctor who is in control. Since she does not see what is occurring, she will, of necessity, have

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5 The partial birth abortion procedure developed by Martin Haskell utilized nitrous-oxide/oxygen administered nasally as an adjunt to local anesthesia. Haskell, *Dilation and Extraction for Late Second Trimester Abortion*. Presented at the National Abortion Federation F&k Management Seminar: Dallas, Texas, September 13, 1992; *see also* Coreen Costello, *Giving Up My Baby*, New York Times Op-Ed, November 23, 1995. A24 where woman was under anesthesia at the time of her partial birth abortion.

6 Examples of the altering of consciousness include using light anesthesia for the actual D & E procedure so the woman has little sense of what is going on as the fetus is dismembered inside her and pulled out with the forceps. Or as another woman put it, " Fifteen minutes or so of Demerol-induced oblivion and that's it." Abbott, *The Abortionist as Craftsman*, 22 Human Life Review 23 (1996). Although denial may occur at the time of the abortion and last for a period of time, it eventually breaks down and women may express a high level of stress from the experience. Among the long term stresses women experienced from D & E abortions, were anxiety regarding pain the fetus may have experienced, and guilt over the knowledge that a second or third trimester fetus had been dismembered. Speckhard, *Psycho-Social Stress Following Abortion*, 79-80 (1987).

to rely on the representations of the doctor.

A study of 250 women at the University of California, San Francisco during the 1970's is a case in point. In this study, women who had undergone mid-second trimester abortions by dilation and extraction under general anesthesia were interviewed three weeks post-abortion. D & E was seen as helpful in getting through an ambivalent situation and as tending to reinforce preexisting denial. The use of general anesthesia led to an experience which was described by the women as "like a dream" and "out of my hands." The researchers found that the D & E patient was consciously aware of avoiding the implications of the procedure and rarely asked any questions. Kaltreider, Goldsmith & Margolis, *The Impact of Mid Trimester Abortion Techniques on Patients and Staff*, 135 Am. J. Obstet. Gynecol. 235 (1979).

This approach violates the standards of the National Abortion Federation. These standards include "Objectives of Decision Counseling" which require that "accurate information" be provided so that "she retains her autonomy and control." These standards further provide, under "Objectives of Informed Consent," that the woman be provided with "accurate information, directly applicable to her procedure, about the risks of surgery, and the benefits of that surgery." In addition, the standards require that the abortion procedure be described "to the patient in terms she can readily understand." *Standards For Abortion Care*, National Abortion Federation 4 (1986). The standards do not provide for any "therapeutic" exceptions. The U.S. Supreme Court in upholding a state statute requiring informed consent prior to abortion stated, "The decision to abort is important and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences." *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976).

B. Pregnant Women Who Are Likely to Seek Partial Birth Abortions Are a Special Population with Significant Disadvantages

Which Increase the Likelihood of Partial Birth Abortion.

i. Characteristics of the Special Population.

The gestational age that the Respondent testified that he intends and prefers to use the intact D & E procedure on is "over 15 weeks." *Carhart v. Stenberg*, 972 F. Supp. 507 at 523. This gestational age for abortion represents a very small percentage of the total number of induced abortions performed in the United States each year. According to the Centers for Disease Control, only 5.8% of the 1,221,585 induced abortions reported in 1996 were performed at 16 weeks of gestation or more. Koonin and Associates, *Abortion Surveillance-United States*, 1996, 48 MMWR No. SS-4, July 30, 1999.

Women who obtain these later abortions are a special population. According to a 1987 survey by the Alan Guttmacher Institute of 420 women seeking abortions at 16 gestational weeks or more at various abortion facilities throughout the United States, they are significantly more likely to be teenagers under the age of 18,[7] black women,[8] unemployed women, women covered by Medicaid,

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7 The National Center for Health Statistics reported detailed abortions statistics for a 14 state area in 1988. Among women under 14 years of age, 14.6% had abortions at 16 gestational weeks or more compared to 13.3% of women age 14, 10.1% of women age 15, 9.2% of women age 16, 7.5% of women age 17, 4.9% of women age 20-24 years, and 3.9% of women age 25-29 years. National Center for Health Statistics, 39 (12) Monthly Vital Statistics Report, Supplement April 30, 1991, Table 10, 11.

8 The National Center for Health Statistics in a 14 state area in 1988, reported that 7.2% of black women had abortions at 16 gestational weeks or later compared to 3.9% of white women. National Center for Health Statistics, 39 (12) Monthly Vital Statistics

women fearing possible fetal health problems, women whose parents wanted them to have an abortion, or women whose pregnancy resulted from rape or incest. Women were significantly less likely to have a later abortion if they were age 30 or older, if they had no religious affiliation, if they were having health problems, or if their husband or partner wanted them to have an abortion. Torres and Forrest, *Why Do Women Have Abortions?*, 20 Family Planning Perspectives 169 (1988) (hereafter called the AGI Survey).

ii. Moral Conflicts.

A substantial number of the women who obtain abortions at 16 gestational weeks or later would be opposed to abortion on moral grounds. This would include religious women, black women and women of low income. A 1981 nationwide poll commissioned by the Connecticut Mutual Life Insurance Company asked, "Do you believe abortion is morally wrong, or is it not a moral issue?" Overall, 67% of females compared to 64% of males believed it was morally wrong. Among those with the lowest religious commitment, only 43% thought it was morally wrong compared to 75% with moderate religious commitment or 85% among those with the highest religious commitment. Blacks were more likely than whites to believe abortion is morally wrong (73% v. 64%). Among those with incomes under $12,000, 74% believed abortion was morally wrong compared to only 56% among those with incomes above $25,000. *The Connecticut Mutual Life Report on American Values in the 80s: The Impact of Belief*, 92 (1981). Some women with moral objections to abortion will still have an induced abortion but it will more likely be a late abortion compared to an early abortion. These moral conflicts include opposition of the woman to abortion and conflicted decisions. Burr and Schulz, *Delayed Abortion in an Area of Easy Accessibility*, 244 JAMA 44 (1980).

iii. Attachment to the Unborn Child.

Report, Supplement, April 30, 1991, Table 10,11.

Women who have abortions in the second trimester are also more likely to use the word "baby " in describing what is in her womb compared to women who have abortions in the first trimester, who are more likely to use words such as "this pregnancy" or "this condition." Kaltreider, *Emotional Patterns Related to Delay in Decision to Seek Legal Abortion*, 118 Calif. Med. 23 (1973). Another study found that pregnant women at more than 16 weeks gestation were much more likely to carry to term if they requested and were denied an abortion compared to women who were 16 weeks gestation or less. Binkin and Associates, *Women Refused Second-Trimester Abortion: Correlates of Pregnancy Outcome*, 145 Am. J. Obstet. Gynecol. 279 (1983).

iv. Indecision and Ambivalence.

Various studies have found that women who obtain abortions in the second trimester have significantly different behavior patterns compared to women obtaining abortions in the first trimester. High levels of indecision and ambivalence have been found in women undergoing mid trimester abortions compared to women having first trimester abortions. Osofsky and Associates, *Psychosocial Aspects of Abortion in the United States*, 42 Mt. Sinai Medical Journal 456 (1975). Researchers at the University of California concluded that "women who delay the decision to abort have a background of greater psychopathology and have difficulty in decision making. They often lack social supports and have difficulty with contraception." Kaltreider, Goldsmith and Margolis, *The Impact of Mid Trimester Abortions of Patients and Staff*, 135 Am. J. Obstet. Gynecol. 235 (1979). Researchers at the Yale University School of Medicine found that those who delayed seeking abortion until the second trimester frequently kept news of the pregnancy from partner and parents, and did not obtain financial help or refused it when offered. They also found that those who waited until the second trimester were often ambivalent about seeking the abortion and, to a lesser degree, were unwilling to accept the possibility of pregnancy. Bracken and Kasl, *Delay in Seeking Induced Abortion: A Review and Theoretical Analysis*, 121 Am. J. Obstet. Gynecol. 1008 (1975).

v. Immaturity.

Psychological immaturity was identified as one of the important factors resulting in delayed abortion in a Washington, D.C. study of 1066 women using multiple regression analysis. Burr and Schulz, (1980). The 1987 Alan Guttmacher Institute survey also found that women under the age of 18 are significantly more likely to obtain abortions at 16 gestational weeks or later compared to women who obtained abortions in the first trimester.[9]

vi. Biological Factors.

A history of irregular periods was found to be the strongest single predictor for women seeking a late abortion in a multiple regression study of Washington, D.C. women, although much of the variation in gestational age was not explained by the analysis.[10] Not knowing soon enough the gestational age of their pregnancy has also been found to be an important factor among women obtaining abortions at 16 weeks gestation or more.[11]

vii. Secrecy and Isolation.

According to a 1987 Alan Guttmacher Institute survey, almost two-thirds (63%) of U.S. women who have abortions as teenagers at 16 weeks gestation or more (and one-third of the overall sample) attributed the delay to being afraid to tell their partner or parent that they were pregnant.[12] Another study of post-abortion women, where women had frequently had second trimester abortions at a young age,

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9 Torres and Forrest (1988)

10 Burr and Schulz (1980)

11 Torres and Forrest (1988)

12 Torres and Forrest (1988)

reported that a great portion of the women did not admit pregnancy until a pregnancy test could no longer be avoided without also jeopardizing their chances to obtain an abortion. Abortion was utilized as a strategy for coping with the pregnancy without ever fully admitting that the pregnancy existed. Speckhard, *Psycho-Social Stress Following Abortion*, 97-98 (1987).

viii. Low Self Esteem and Identity Conflicts.

Poor ego strength and low self-esteem were found among women undergoing second trimester abortions at a Planned Parenthood of San Francisco facility.[13] Another study of New York City women found that abortion at later gestational ages was significantly associated with a greater disturbance of the basic sense of self due to gender/sexual conflict and lower levels of internalized striving or ambition. Cancelmo and Associates, *Psychodynamic Aspects of Delayed Abortion Decisions*, 65 Br. J. Medical Psychology 333 (1992).

ix. Lack of Resources and an Inability to Receive or Accept Assistance.

The Alan Guttmacher 1987 survey of women who obtained abortions at 16 weeks gestation or later found that unemployed women and women receiving Medicaid were more likely to have later abortions compared to women who had first trimester abortions.[14] Researchers at the Yale University School of Medicine found that it was characteristic of women who delay abortions not to obtain financial help or to refuse it when offered.[15] Kaltreider and Colleagues found that women who obtained second trimester

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13 Kaltreider (1973)

14 Torres and Forrest (1988)

15 Bracken and Kasl (1975)

abortions often lacked social supports and spoke more often of assessing the resources available to help them keep a child compared to women with first trimester abortions.[16]

x. Non-Use of Contraceptives.

Researchers have found that women who obtain second trimester abortions do not use contraceptives or use contraceptives to a lesser degree compared to women obtaining first trimester abortions. Researchers at the Yale University School of Medicine concluded that "available studies suggest that unprotected coitus correlates with delay in seeking an abortion."[17] The Washington, D.C. study which used multiple regression analysis to determine what factors are related to the gestational stage at which women seek an abortion found that contraceptive use predisposed women to earlier abortions.[18]

xi. Influence by Doctors or Genetic Counselors.

Doctors and other professionals may encourage abortions if there is a possibility that the baby would be born with a handicap, and may reinforce the parent's fear that they may not be equal to the task if a handicapped child were born, and that a special needs child would be too great a financial burden. Vought, *Post-Abortion Trauma*, 61 (1991) (citing other authorities). Prenatal diagnosis can be very stressful. Moral, religious or philosophical concerns may predominate. Rice and Doherty, *Reflections on Prenatal Diagnosis: The Consumers Views*, 8 Social Work in Health Care 47 (1982). If there is a crisis, a minimal amount of effort by a counselor or doctor may be able to exert a maximum amount of leverage on the stressed

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16 Kaltreider (1973); Kaltreider, Goldsmith & Margolis (1979)

17 Bracken and Kasl (1975)

18 Burr and Schulz (1980)

individuals. Morley, *Theory of Crisis Intervention*, 21 Pastoral Psychology 203 (1970).

A 1987 Alan Guttmacher Institute survey of U.S. women who obtained abortions at 16 weeks gestation or more found that 2% did so because a fetal problem was diagnosed late in pregnancy.[19] There is evidence that the incidence of partial birth abortions for reason of fetal defects is much higher, at least for one doctor. In 1995, James McMahon reported on a series of 1362 intact D & E abortions done over a 13 year period of which approximately one-third were reported to have been done on the basis of serious indication of fetal defect. Haskel, Easterling & Lichtenberg, *Surgical Abortion After the First Trimester in A Clinicians Guide to Medical and Surgical Abortion*, Paul, Maureen, 135-137 (1999). Induced abortions for genetic reasons have a high incidence of severe adverse psychological reactions.[20]

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19 Torres and Forrest (1988)

20 *See* e.g. Furlong and Black, *Pregnancy Termination for Genetic Indications: The Impact on Families*, 10 Social Work in Health Care 17 (1964) (even very young children may show reactions from parents' distress and maternal absence); Kolker and Burke, *Grieving the Wanted Child: Ramifications of Abortion After Prenatal Diagnosis of Abnormality*, 14 Health Care for Women Int'l. 513 (1993) (there is little understanding and societal support for those who experience abortion because of fetal defect); Suslak, Scherer and Rodriguez, *A Support Group for Couples Who Have Terminated a Pregnancy After Prenatal Diagnosis*, 4 Journal of Genetic Counseling 169 (1995) (severe reactions to termination of pregnancy included loss of self-esteem, hindrance of socialization, guilt from having killed their baby, difficulty in returning to church, grief reactions. Couples referred to the loss of their "baby" rather than the loss of their "fetus"); Rayburn and Laferla, *Mid-Gestational Abortion for Medical or Genetic Indications*, 13 Clinics in Obstetrics and Gynecology 71 (1986) (the psychological difference between elective

III. The State Has an Interest in the Moral Status of the Unborn Child Because Neither Abortion Professionals Using the Partial Birth Abortion Method Nor Medical Societies Protect this Interest.

A. Moral Dilemmas of Abortion Facility Workers.

Although the woman does not witness the dismemberment of the unborn child or see the unborn child stabbed in the back of its head and the contents of its brains removed, the medical doctor sees exactly what occurs because he or she is performing the act. For this reason, some medical doctors will not perform such a procedure. In the University of California, San Francisco study , one doctor who did abortions by the intra-amnoitic injection of prostaglandin but would not perform D & E's said, "Killing a baby is not a way I want to think about myself." It was reported that two doctors who did all of the D & E's in the study supported each other and relied upon a strong sense of social conscience[21] founded upon the health and desires of the

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and medically indicated abortions is extreme. Women going through elective abortion will primarily feel relieved while in those for genetic or maternal abnormality, a grief response is to be expected). Mothers who have an abortion for a genetic abnormality are at higher risk of requiring prolonged psychiatric hospitalization in the next 12 months); Blumberg, Gofbus & Hanson, *The Psychological Sequelae of Abortion Performed for a Genetic Indication*, 122 Am. J. Obstet. Gynecol. 799 (1975) (a high incidence of depression and other severe reactions was found among both men and women as well as a threat to family integrity, where women had undergone abortions for a prenatal detection of a genetic defect in the fetus.)

21 Whether or not induced abortion advances the social and economic status of women is problematical. A study by researchers at Yale University School of Medicine found that women with repeat abortions were more likely to be divorced and more likely to be welfare recipients compared to women with a single abortion.

woman. They felt technically competent but had strong emotional reactions during or following the procedures and occasional disquieting dreams. Kaltreider, Goldsmith and Margolis, *The Impact of Mid Trimester Abortion Techniques on Patients and Staff*, 135 Am. J. Obstet. Gyneco. 1235 (1979). A small study examined the emotional reactions of abortion facility staff to D & E abortions up to 23 weeks. Reactions to the fetus ranged from purposely not looking at it, to shock, dismay, amazement, disgust, fear, and sadness. Attitudes toward the doctor included sympathy, wonder at how he could perform the D & E at all, and a desire to protect him from the trauma. Distancing, projection and rationalization were used by staff to handle the traumatic impact of the destructive part of the operation and the procedure was viewed as destructive and violent. Many reported serious emotional reactions that produced physiological symptoms, like sleep disturbances, effects on interpersonal relationships, and moral anguish. Hern, *What About Us? Staff Reactions to D & E*, 15 Advances in Planned Parenthood 3 (1980).

The partial birth abortion (or intact D & E) is similarly very troublesome and distressing. It was graphically described by Brenda Pratt Shafer, a nurse who worked for Martin Haskell in Dayton, Ohio (in September, 1993) in testimony before the House Judiciary Committee on March 21, 1996. She said, in relevant part:

Shepard and Bracken, *Contraception and Repeat Abortion*, 11 Journal of Social Science 289 (1979). Overall, 60% of U.S. women who have an abortion will repeat abortion by age of 30. Henshaw and Kost, *Abortion Patients in 194-1995: Characteristics and Contraceptive Use*, 28 Family Planning Perspectives 140 (1996). A long term study also found that women with an abortion history were more likely to exhibit multiple problem behavior, have lower occupational prestige, be similar in educational attainment and have only slightly higher personal income compared to women with no abortion history. Costa and Associates, *Psychosocial Correlates and Antecedents of Abortion: An Exploratory Study*, 9 Population and Environment 3 (1987).

The mother was 6 months pregnant, 26 1/2 weeks. A doctor told her that her baby had Down Syndrome, and she decided to have an abortion. She came in the first two days to have the laminaria inserted and changed, and she cried the whole time. On the third day she came in to receive the partial birth abortion (called D & X by Martin Haskell). Dr. Haskell brought in ultrasound in and hooked it up, so that he could see the baby. I could clearly see the baby's heartbeat on the ultrasound screen. Dr. Haskell went in with forceps and grabbed the baby's legs and pulled them down into the birth canal. Then he delivered the baby's body and arms-everything but the head. The doctor kept the baby's head just inside the uterus. The baby's little fingers were clasping and unclasping, and his feet were kicking. Then the doctor stuck the scissors through the back of his head, and the baby's arms jerked out in a flinch, a startle reaction, like a baby does when you throw him up in the air and he thinks he might fall. The doctor opened up the scissors, stuck a high-powered suction tube into the opening, and sucked the baby's brains out. Now the baby went completely limp. I was really completely unprepared for what I was seeing. I almost threw up as I watched the doctor do these things. Dr. Haskell delivered the baby's head. He cut the umbilical cord and delivered the placenta. He threw that baby in a pan along with the placenta and the instruments he used. I saw the baby move in the pan and I asked another nurse and she said it was just "reflexes."

The woman wanted to see her baby, so they cleaned the baby up and put it in a blanket and handed the baby to her. She cried the whole time. Looking down into the baby's face, she said, "Please forgive me. I am so sorry. I love you." I was crying, too. I couldn't take it. That baby boy had the most perfect angelic face you've ever seen. I was present in the room for two more such procedures that day, but I think I was really in shock. I tried to pretend that I was somewhere else, to not think about what was happening. I just couldn't wait to get out of there. And after I left that day, I never went

back. These last two procedures involved healthy mothers with healthy babies. I was very much affected by what I had seen.

Brenda Pratt Shafer, R.N., *Testimony before Subcommittee on the Constitution, House Judiciary Committee, March 21, 1996*, reprinted in 14 Issues in Law and Medicine 99-100 (1998).

James McMahon, one of the doctors who utilized the partial birth abortion procedure which he called intact D & E, expressed moral reservations about the procedure. He was quoted in the press as saying,

> I have two positions that may be internally inconsistent, and that's probably why I fight this all the time. I do have moral compunctions. And if I see a case that's later, like after 20 weeks where it frankly is a child to me. I really agonize over it because the potential is so imminently there. I think, 'Gee, it's too bad that this child couldn't be adopted.' On the other hand, I have another position, which I think is superior in the hierarchy of questions, and that is: 'Who owns the child?' It's got to be the mother.

Gianelli, *Shock-tactic Ads Target Late-term Abortion Procedure*, American Medical News, p. 21, July 5, 1993.

B. Medical Doctors Fail to Protect the Moral Status of the Unborn Child in the Partial Birth Abortion Context.

Medical doctors and other abortion facility personnel either refuse to perform late stage abortions by quitting, or they may attempt to seek out social support in order to permit themselves to do so, or repress their emotions in some manner in order to involve themselves in the procedure.

i. The Doctor as a Technician.

Despite his moral reservations, James McMahon appeared to have concentrated on the technical aspects of intact D & E abortions. In an interview in 1990 he was quoted as saying regarding abortion, "That's my specialty ... that's my expertise. That's my passion ... Frankly, I don't think I was any good at all until I had done 3000 or 4000." Abbott, *The Abortionist as Craftsman*, 22 Human Life Review 23 (1996). Adopting new technical approaches to solve problems may increase confidence, and relieve stress. Hern, *What About Us? Staff Reactions to D & E*, 15 Advances in Planned Parenthood 3 (1980), but the doctor who does so is likely to become no more than a technician.

If one concentrates their energies and passion to improving the technique of abortion as in the case of James McMahon, becoming technically proficient is done at the expense of human values. One of the values lost is the respect for the dignity of human life in the womb. The loss of important values is often overlooked because the implicit and largely unchallenged argument seems to be that if the procedure is carried out by a technological specialist (a physician) in accordance with recognized medical practice, there is no need to be concerned about the purpose of the operation. However, dominant themes of the technological world are in conflict with the moral world. Hunt, *Technological Themes in the Abortion Debate in When Life and Choice Collide*, Ed David Mall, 255-258 (1994). French philosopher and theologian, Jacques Ellul, has identified modern technique as a form of idolatry noting that "Technique worships nothing (and) respects nothing." Ellul, *The Technological Society*, 142 (1964). Thus, barbaric practices can enter a society and may go unchallenged.

ii. The Medical Profession Fails to Protect the Moral Status of the Unborn Child in the Context of Partial Birth Abortion.

The American College of Obstetricians and Gynecologists (ACOG) guidelines on ethical decision-making states,

> In the care of the obstetric patient, the traditional physician-patient relationship expands to include the fetus. The physician retains an obligation to respect the autonomy of the pregnant woman while promoting her medical well-being. In addition, the physician must assume an obligation of beneficence (promoting the well-being of others) toward a second patient, the fetus. The weight that this obligation is given in comparison with previously established obligations to the woman is central to many ethical dilemmas in the practice of obstetrics.

Ethical Decision-Making in Obstetrics and Gynecology, ACOG Technical Bulletin No. 136, November, 1989. However, in the situation where the woman undergoes an abortion, the obligation of the physician toward the fetus breaks down as the autonomy of the woman is considered paramount.

Therefore, neither the American Medical Association (AMA) nor the American College of Obstetricians and Gynecologists (ACOG) recognizes the fetus as a patient or recognizes the moral status of the fetus or child within the context of partial birth abortions (intact D & E). There is no condemnation of nor limitation on inhumane or cruel procedures which take place in intact D & E partial birth abortions. In 1996, ACOG convened a special panel to review the intact D & X procedure which resulted in an ACOG policy statement which declared that the select panel "could identify no circumstances under which this procedure would be the only option to save the life or preserve the health of the woman" and that "an intact D & X however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision." *ACOG Statement of Policy*, approved by the executive board January 12, 1997. No specific examples of circumstances were given when an intact D & X would be the most appropriate procedure.

Similarly, the American Medical Society has concluded that:

> according to the scientific literature, there does not appear to be any identified situation in which an intact D & X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D & X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

AMA Policy: Women Physicians and Women's Health Issues, "Late-Term Pregnancy Termination Techniques" (H-5.982) 1998.

The state can regulate the practice of medicine in the context of abortion. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992) (upholding state statute requiring doctor to offer woman materials on fetal development) or in the interest of prohibiting immoral conduct. *Planned Parenthood of Wisconsin v. Doyle*, 44 F. Supp. 2d 975 (W.D. Wis. 1999).

CONCLUSION

Daniel Callahan has observed that courts and legislatures are increasingly forced to play the mediator for blocks of interests with nothing in common and forced to do what in great part should be done by ingrained cultural values: provide a framework of morals and a common ethical core to govern humane societal relationships. He states "contemporary individualism not only dissolves all culture - and thus all limits to human behavior - but also mixed with radical technology, sets the stage for unprecedented barbarism." Callahan, *The Tyranny of Survival* (1973). Partial birth abortion is barbaric and the state of Nebraska has an interest in banning its practice on the basis that it is immoral and that Nebraska recognizes the moral status of the unborn child in this limited context.

For all of the compelling reasons set forth above, the judgment of the Court of Appeals should be reversed and the law permitted to go into effect.

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In The

Supreme Court of the United States

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Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

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STATEMENT OF INTEREST OF THE *AMICI CURIAE*

Amici Curiae have a substantial interest in the disposition of this case. Louisiana and Mississippi have both enacted statutory bans on "partial birth abortion." Louisiana's ban was permanently enjoined in federal district court, and is now pending before the United States Court of Appeals for the Fifth Circuit. Mississippi's partial birth abortion ban has not been challenged, and is currently in effect.

Amici believe that bans on partial birth abortion are constitutional because this Court's abortion jurisprudence does not prevent a state from prohibiting the killing of a child in the process of being born. *Amici* present to this Court a constitutional argument supported by both precedent and medical science.

SUMMARY OF THE ARGUMENT

The abortion liberty has always been defined by this Court as a woman's right to "terminate her pregnancy." *See e.g., Planned Parenthood v. Casey*, 505 U.S. 833, 844 (1992). Medical science establishes that the onset of the birth process terminates pregnancy. Therefore, any ban on killing after the onset of the process of birth does not interfere with the right to terminate pregnancy. Consequently, this Court's abortion jurisprudence, including analytical concepts such as undue burden and viability, does not govern the question of whether Nebraska's ban on killing a child in the process of birth is constitutional. As Justice Marshall commented during the second oral

argument in *Roe*, killing a child in the process of birth "is not an abortion."

Because abortion is not prevented by Nebraska's ban on killing a child after pregnancy has been terminated, Nebraska's ban is constitutional if it is rationally related to a legitimate state interest. *See Washington v. Glucksberg*, 521 U.S. 702 (1997). Nebraska's ban on killing a child in the process of birth is reasonably related to its interest in preventing the erosion of the line between abortion and infanticide. Nebraska's concern is neither hypothetical nor irrational.

Nebraska acted reasonably to prevent infanticide from ever becoming a reality. Because its ban on the killing of a child in the process of birth does not regulate the "termination of pregnancy," this Court should reverse the lower court and uphold the Nebraska Partial Birth Abortion Act.

ARGUMENT

I. THE NEBRASKA STATUTE DOES NOT CREATE AN UNDUE BURDEN ON THE RIGHT TO ABORTION BECAUSE, AS JUSTICE MARSHALL COMMENTED DURING THE REARGUMENT OF *ROE*, KILLING A CHILD IN THE PROCESS OF BEING BORN "IS NOT AN ABORTION."

A. Undue Burden Analysis Does Not Apply to Nebraska's Ban on Killing a Child During the Process of Birth.

Since 1973, this Court has consistently defined the abortion liberty as the right of a woman to choose

"whether or not to **terminate her pregnancy**." *Roe v. Wade*, 410 U.S. 113, 153 (1973) (emphasis added). As set forth below, medical science establishes that the onset of the birth process terminates pregnancy. Therefore, Nebraska's ban on killing a child in the process of being born addresses conduct that intentionally occurs *after* termination of the pregnancy. Consequently, Nebraska's Legislative Bill 23 of 1997 ("LB 23")[1] does not interfere with the right to terminate pregnancy, and this Court's abortion jurisprudence, including the undue burden standard, does not govern the question of whether LB 23 is a constitutional exercise of legislative authority.

During the 1972 reargument of *Roe*, this Court discussed whether the term "abortion" encompassed killing a child during the process of birth. The following exchange between Justice Marshall and counsel for the State of Texas occurred in the context of a discussion about the Texas parturition statute, which had not been challenged as unconstitutional:

. . . .

JUSTICE MARSHALL: What does that [parturition] statute mean?

MR. FLOWERS: Sir?

JUSTICE MARSHALL: What does it mean?

MR. FLOWERS: I would think that –

JUSTICE STEWART: That it is an offense to kill a child in the process of childbirth?

---

[1] Codified as Neb. Rev. Stat. Ann. §§ 28-326(9), 28-328 (Supp. 1998).

MR. FLOWERS: Yes sir. It would be immediately before childbirth, or right in the proximity of the child being born.

JUSTICE MARSHALL: Which is not an abortion.

MR. FLOWERS: Which is not – would not be an abortion, yes, sir. You're correct, sir. It would be homicide.

. . . .

Reargument of Roe v. Wade, October 11, 1972 (emphasis added) (*see* Appendix A at 3).[2]

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[2] The entire written transcript of the October 11, 1972 reargument, along with a link that plays the audio tape, can be found at the Northwestern University web site: *http://oyez.nwu.edu/support/cases/334/reargument.html*.

This exchange followed Flowers' comment that the plaintiffs had attacked Texas' abortion statutes, found at Articles 1191 through 1196, with the exception of Article 1195. Flowers then quoted the entirety of the unchallenged Article 1195, which provides: "Whoever shall during parturition of the mother destroy the vitality or life in a child in a state of being born and before actual birth, which child would otherwise have been born alive, shall be confined in the penitentiary for life or for not less than five years." This provision is currently codified at Tex. Rev. Civ. Stat. Ann. art. 4512.5.

This Court's decision in *Roe* acknowledged in footnote 1 that Texas' parturition statute was "not attacked." 410 U.S. at 117 n.1. In 1974, a Texas Attorney General opinion echoed Justice Marshall, concluding that Article 1195 is "unaffected" by *Roe* because the element requiring that the child "be in a state of being born" means that the article **"is not, in truth, an abortion statute."** *Tex. Op. Atty. Gen.*, Opinion No. H-369 at 3 (August 13, 1974) (emphasis added).

B. The Right to "Terminate Pregnancy" Does Not Include the Right to Kill a Child During the Process of Birth; There is no Such Thing as a Vaginal Abortion.

Justice Marshall's comment that killing a child in the process of birth "is not an abortion" is fully supported by established medical science. It is also confirmed by this Court's consistent definition of the abortion liberty as the right to terminate pregnancy.

1. Medical science establishes that pregnancy is terminated by the onset of the birth process.

In *Roe*, this Court's understanding of abortion was informed by medical science: "[the pregnant woman] carries an embryo and, later, a fetus, if one accepts the medical definitions of the developing young in the human **uterus**." 410 U.S. at 159 (emphasis added) (*citing* DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 478-479, 547 (24th ed. 1965)). Nebraska, like this Court in *Roe* and its progeny, also relied upon medical definitions when it enacted LB 23. Because medical science establishes that pregnancy is terminated by the onset of the birth process, LB 23 does not regulate "abortion," as that term is understood both medically and legally.

The development of a human being takes place in two stages. The first stage is pregnancy, which begins at conception and ends when the living child is delivered or removed from the uterus into the birth canal. *See* TABER'S CYCLOPEDIC MEDICAL DICTIONARY 1543, 2046 (18th ed. 1997) (defining *pregnancy* as the "condition of carrying an

embryo [or fetus] in the uterus;" defining *uterus* as "[a] reproductive organ for containing and nourishing the embryo and fetus . . . to the time the fetus is born"). As such, the pregnancy stage is confined to the development of the child while in the uterus of his or her mother.

The stage after pregnancy is birth, followed by the whole process of postnatal growth through adulthood and old age. The birth stage starts when the living child begins to exit the womb into the birth canal.[3] *See* TABER's at 223 (defining *birth* as the "passage of a child from the uterus"); *see also* DORLAND's at 202 (28th ed. 1994) (defining *birth* as "the act or process of being born" and *complete birth* as "the complete separation of the infant from the maternal body (after cutting of the umbilical cord)").[4]

Vaginal birth is an irreversible process, not a single event. As a matter of medical fact, pregnancy is terminated and the process of birth has begun once the membranes of the amniotic sac are ruptured and the living fetus emerges from the uterus, beyond the cervical os and into the vaginal (birth) canal. *See Declaration of Jack A. Andonie, M.D.*, ¶¶ 8-10 (Appendix B); *Declaration of Raymond Gasser*, Ph.D., ¶¶ 10-11 (Appendix C).[5] Thus, there is a significant medical distinction between the locus where intrauterine fetal stasis is maintained (i.e., pregnancy), and the dynamic process of birth. Pregnancy has never occurred or been maintained in the vaginal canal.[6] The delivery of the child into the birth canal means that the complete birth of the child is inevitable.

In the medical vernacular, the onset of the birth process is one method of terminating a pregnancy, while induced abortion is another.[7] Medically, then, it is an oxymoron to speak in terms of "aborting" a living fetus that is partially vaginally delivered. This is so because induced abortion is any procedure that causes fetal death in utero, thereby causing "the premature expulsion from the uterus of the products of conception."[8] In other words, there is no such thing as a "vaginal abortion." That non-medical term is simply a euphemism for the

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[3] The terms womb and uterus are interchangeable. *See* DORLAND's at 1846 (womb is defined as "the uterus").

[4] In *Roe*, this Court did not "resolve the difficult question of when life begins," because "the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer." 410 U.S. at 159 (emphasis added). Here, by contrast, there is no need to speculate about when birth begins. There is no raging debate or lack of consensus about the process of birth among "those trained in the respective disciplines of medicine, philosophy, and theology." *Id.*

[5] The Declarations of Dr. Andonie and Dr. Gasser are part of the official record in the Louisiana partial birth abortion case currently pending in the United States Court of Appeals for the Fifth Circuit, which is set for oral argument on March 2, 2000. *Causeway Medical Suite v. Foster*, No. 99-30324 (5th Cir.), *on appeal from* 43 F. Supp. 2d 604 (E.D. La. 1999). These basic and unquestionable medical facts testified to by Louisiana's medical experts were not controverted.

[6] App. 8, *Andonie Decl.* at ¶ 10; App. 16, *Gasser Decl.* at ¶ 11.

[7] App. 8, *Andonie Decl.* at ¶ 6.

[8] DORLAND's at 4; App. 8, *Andonie Decl.* at ¶¶ 6-7. Actually, the phrase "fetal death in utero" is a tautology because "fetal death" means "death in utero." DORLAND's at 430.

criminal termination of the life of a child after the pregnancy has already been terminated by the onset of the process of birth.

Therefore, in enacting LB 23, the legislature was not regulating abortion at all, as that term is medically understood. Rather, Nebraska proscribed the killing of a child after the process of birth has begun, and labeled that crime "*partial birth* abortion."[9]

That LB 23 is not in fact regulating abortion is a conclusion supported by medical science. The intentional delivery of a living child from the uterus into the vaginal canal signals a momentous medical, and now legal, event. Thus, where LB 23 speaks in terms of "partially delivers vaginally a living unborn child" it has thereby given effect to the medical distinction between pregnancy and birth. By its terms, then, LB 23 regulates the process of birth, also referred to as parturition.[10]

---

[9] Although "partial birth abortion" is not a medical term, it has become a legal term of art that was adopted by Nebraska to describe the crime of killing a child in the process of being born.

[10] In 1992, the pioneer of the partial birth abortion procedure, Dr. Martin Haskell, distinguished his so-called "intact D&X" procedure from the "established D&E" method: "Classic D&E is accomplished by dismembering the fetus **inside the uterus** with instruments and removing the pieces through an adequately dilated cervix." Martin Haskell, M.D. *Dilation and Extraction for Late Second Trimester Abortion* 28 (NAF, Sept. 13, 1992) (emphasis added) (citing Grimes, D.A., Cates, W. Jr. (Berger, G.S., et al., ed.): Dilation and Evacuation, *Second Trimester Abortion – Perspectives After a Decade of Experience*, Boston, John Wright-PSG, 1981, p. 132.). Contrary to Haskell's description, Respondent Carhart claims he performs a procedure that he calls "D&E" in which fetal dismemberment takes place in the birth canal, i.e., by delivering a limb into the vaginal canal and using the cervical os as traction to dismember the child. *Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1103 (D. Neb. 1998), *aff'd*, 192 F.3d 1142 (8th Cir. 1999), *cert. granted*, 120 S.Ct. 865 (U.S. Jan. 14, 2000).

Respondent Carhart claims that LB 23's ban on killing during the birth process would prevent him from doing these so-called "D&Es." Respondent Carhart is wrong. Merely pulling a limb into the birth canal, is not, for Nebraska, enough to trigger the statute. Although *Amici's* inevitable birth argument explains why pulling a limb into the birth canal terminates pregnancy, Nebraska has not legislated to the full extent the argument would support.

2. Abortion jurisprudence recognizes only a woman's right to terminate her pregnancy; this Court has never held that there is a right to kill a child in the process of being born.

This Court has consistently formulated the abortion liberty as a woman's right to "terminate her pregnancy." For example, in *Roe*, this Court stated,

> This right of privacy . . . is broad enough to encompass a woman's decision whether or not to **terminate her pregnancy.**

Roe, 410 U.S. at 153 (emphasis added).

Similarly, in *Casey*, this Court stated:

> From what we have said so far it follows that it is a constitutional liberty of the woman to have some freedom to **terminate her pregnancy.**[11]

Casey, 505 U.S. at 869 (emphasis added).

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[11] In *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), this Court repeatedly articulated the abortion liberty as a "woman's right to **terminate her pregnancy**":

> "Yet 19 years after our holding that the Constitution protects **a woman's right to terminate her pregnancy** in its early stages . . . , that definition of liberty is still questioned." *Id.* at 844. "Constitutional protection of **the woman's decision to terminate her pregnancy** derives from the Due Process Clause of the Fourteenth Amendment." *Id.* at 846. "The extent to which the legislatures of the States might act to outweigh the interests of the woman in choosing to **terminate her pregnancy** was a subject of debate both in *Roe* itself and in decisions following it." *Id.* at 853. "We conclude that the basic decision in *Roe* was based on a constitutional analysis which we cannot now repudiate. The woman's liberty is not so unlimited, however, that from the outset the State cannot show its concern for the life of the unborn, and at a later point in fetal development the State's interest in life has sufficient force so **that the right of the woman to terminate the pregnancy** can be restricted." *Id.* at 869. "We conclude the line should be drawn at viability, so that before that time **the woman has a right to choose to terminate her pregnancy**." *Id.* at 870. "The woman's right to **terminate her pregnancy** before viability is the most central principle of *Roe v. Wade*." *Id.* at 871. "Though **the woman has a right to choose to terminate** or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed." *Id.* at 872. " '*Roe* did not declare an unqualified constitutional right to an abortion, as the District Court seemed to think. Rather, the right protects the woman from unduly burdensome interference with **her freedom to decide whether to terminate her pregnancy.**' " *Id.* at 874 (quoting *Maher v. Roe*, 432 U.S. 464, 473-474 (1977) (internal quotation marks omitted)). "All abortion regulations interfere to some degree with a **woman's ability to decide whether to terminate her pregnancy.**" *Id.* at 875. "Not all burdens on the right to decide whether **to terminate a pregnancy** will be undue." *Id.* at 876. "Our adoption of the undue burden analysis does not disturb the central holding of *Roe v. Wade*, and we reaffirm that holding. Regardless of whether exceptions are made for particular circumstances, a State may not prohibit any woman from making the ultimate decision to **terminate her pregnancy** before viability." *Id.* at 879. "Whether the mandatory 24-hour waiting period is nonetheless invalid because in practice it is a substantial obstacle to **a woman's choice to terminate her pregnancy** is a closer question." *Id.* at 885. "Rather, the right protected by *Roe* is a **right to decide to terminate a pregnancy** free of undue interference by the State." *Id.* at 887 (emphasis added to all quotations).

Once the child has moved from the pregnancy stage to the birth stage, a woman's right to "terminate her pregnancy" is not implicated because there is no longer a pregnancy to terminate. After commencement of the birth process, the intentional ending of the life of a partially born child is not an abortion at all, but rather the unlawful killing of a human being.

In *Wynn v. Scott*, federal district judge Marshall addressed a hypothetical statute providing that if a physician had a choice of procedures to terminate the

pregnancy, both of equal risk to the woman, the state could require the physician to choose the procedure which is least likely to kill the fetus. The court concluded that "[t]his choice would not interfere with the woman's right to terminate her pregnancy. It never could be argued that she has a constitutionally protected right to kill the fetus. She does not." 449 F. Supp. 1302, 1321 (N.D. Ill. 1978), *appeal dismissed*, 439 U.S. 8 (1978), *aff'd sub nom., Wynn v. Carey*, 599 F.2d 193 (7th Cir.1979) (citing Note, *Medical Responsibility of Fetal Survival Under Roe and Doe*, 10 Harv. Civ. Lib.-Civ. Rt. Rev. 444 (1975)).

The abortion liberty is not so broad that a woman may terminate her pregnancy " 'at whatever time, in whatever way, and for whatever reason she alone chooses.' " *Planned Parenthood v. Danforth*, 428 U.S. 52, 60 (1976) (quoting *Roe*, 410 U.S. at 153). Although a woman may have a qualified right to an empty womb, this Court has never held that she has a right to a dead child. *Cf. Planned Parenthood v. Ashcroft*, 462 U.S. 476, 483 n.7 (1983) (plurality) (describing as "remarkable" testimony of abortion provider Dr. Robert Crist that " 'the abortion patient has a right not only to be rid of the growth, called a fetus in her body, but also has a right to a dead fetus' ").

3. The abortion-related concept of viability is irrelevant.

Amici recognize the principle outlined in *Casey* that "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion." *Casey*, 505 U.S. at 846. However, because medical science establishes

that pregnancy is terminated by the onset of the birth process, LB 23 does not regulate "abortion," as that term is understood both medically and legally.

"Viability" is about gestation; "partial birth abortion" is about location. Viability is a variable in the equation this Court developed to determine the strength of a state's interest in protecting an unborn child, as weighed against the right of the woman to choose to terminate her pregnancy. The issue of whether a state may protect the life of the unborn child necessarily arises prior to the time that the pregnancy has been terminated, *i.e.*, while the fetus is gestating in the womb. Thus, the pregnancy stage provides the only occasion where the decision of whether or not to permit the killing of a human being is dependent upon his or her viability.[12]

When the child has been delivered from the uterus into the vaginal canal, the woman is no longer "pregnant." Thus, abortion jurisprudence regarding viability does not provide the proper analytical framework to assess an asserted right to kill a child after the pregnancy has been terminated by the onset of the birth process. A state's authority to ban killing during the birth process should not, therefore, depend on whether the partially born child's gestational age is nine months or five months; whether the birth has begun naturally or has

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[12] This Court has never before addressed the issue of whether a State law that bans the intentional killing of partially born infants, whether viable or nonviable, is constitutional. *See* footnote 2, *supra* (discussing the Texas parturition statute that was "not attacked" in *Roe*).

been artificially induced; or whether the child is "viable" or "nonviable."

To expand the concept of viability to the process of birth would transform the right to terminate pregnancy into a new constitutional right to kill a child even after the pregnancy is terminated. Application of abortion principles to statutes regulating birth would thus erode the barrier between abortion and infanticide.[13]

II. LB 23 ADVANCES NEBRASKA'S LEGITIMATE INTEREST IN PREVENTING THE EROSION OF THE LINE BETWEEN ABORTION AND INFANTICIDE.

LB 23 regulates the process of birth, not abortion. Consequently, the subjective medical judgment of the abortion provider must give way to the state's regulation as long as it has a rational basis. LB 23 is rationally related to Nebraska's legitimate interest in preventing the erosion of the line between abortion and infanticide.[14]

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[13] This Court has stated that, in the context of abortion, the issue of maternal "health" can override a state's interest. *See e.g., Doe v. Bolton*, 410 U.S. 179, 192 (1973). Here, where Nebraska is regulating the process of birth to prevent the slide to infanticide, the issue of maternal health, absent a risk to the mother's life, also does not override the state's interest.

[14] The term "infanticide" is defined as

> The murder or killing of an infant soon after its birth. The fact of the birth distinguishes this act from 'feticide' or 'procuring abortion,' which terms denote the destruction of the fetus **inside the womb**.

BLACK'S LAW DICTIONARY 699 (5th ed. 1979) (emphasis added).

This Court's recent decision in *Washington v. Glucksberg*, 521 U.S. 702 (1997), is instructive on this point.

In *Glucksberg*, this Court held that a state has the right to proscribe, not merely regulate, physician-assisted suicide notwithstanding a physician's best medical judgment that assisted suicide is the best and most appropriate way to relieve a patient's pain or terminal illness. *Id.* at 734. The State of Washington argued that "permitting assisted suicide will start it down the path to voluntary and perhaps involuntary euthanasia." *Id.* at 732. This Court agreed: "Washington's ban on assisting suicide prevents such erosion." *Id.* at 733 (emphasis added). Because no fundamental right was implicated, a rational basis analysis was applied to reach the conclusion that "Washington's ban on assisted suicide is at least reasonably related to [its] promotion and protection" against abuses that could lead to the involuntary euthanasia of vulnerable neonates or elderly adults. *Id.* at 734.

Like Washington's ban on assisted suicide, Nebraska's ban on killing a child in the process of birth is reasonably related to its interest in preventing the erosion of the line between abortion and infanticide. Stated differently, LB 23 creates a firewall against infanticide upon the line that this Court has consistently drawn – "termination of pregnancy."[15]

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[15] The issue of whether a partially born human being is a "person" under the Fourteenth Amendment need not be reached by this Court to uphold LB 23. The fact that the partially born child is a living human being provides the State with a legitimate interest in preventing the killing of that child *after* the active process of birth has terminated the pregnancy. By

Nebraska's concern with avoiding the slippery slope to infanticide is neither hypothetical nor irrational. It is not hypothetical because serious proposals for the legalization of infanticide have been championed by prominent academicians. For example, Professor Peter Singer, who holds an endowed chair at Princeton University, justifies infanticide based on his position that "[i]f the fetus does not have the same claim to life as a person, it appears that the newborn baby does not either, and the life of a newborn baby is of less value to it than the life of a pig, a dog, or a chimpanzee is to the nonhuman animal." Peter Singer, *Practical Ethics* 169 (2d ed., Cambridge Univ. Press 1997). The following passage illustrates Singer's reasoning:

> [T]he fact that a being is a human being, in the sense of a member of the species Homo sapiens, is not relevant to the wrongness of killing it; it is, rather, characteristics like rationality, autonomy, and self-consciousness that make a difference. Infants lack these characteristics. Killing them, therefore, cannot be equated with killing normal human beings, or any other self-conscious beings. This conclusion is not limited to infants who, because of irreversible intellectual disabilities, will never be rational, self-conscious beings. . . . No infant – disabled or not – has as strong a claim to life as beings capable

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creating a barrier between abortion and infanticide, LB 23 is constitutional under rational basis scrutiny, such as applied in *Glucksberg*.

> of seeing themselves as distinct entities, existing over time.[16]

Id. at 182.

Nebraska's concern is not irrational because LB 23 is reasonably related to preventing the slippery slope to infanticide. Chief Judge Posner of the United States Court of Appeals for the Seventh Circuit criticizes bans on partial birth abortion as being "irrational" because such bans would not prevent "killing the [same] fetus in utero." *Planned Parenthood v. Doyle*, 162 F.3d 463, 471 (7th Cir. 1998) (Posner, J.); *see also Hope Clinic v. Ryan*, 195 F.3d 857, 878-879 (7th Cir. 1999) (*en banc*), *petition for cert. filed*, Jan. 10, 2000 (No. 99-1152) (Posner, J., dissenting). Judge Posner's criticism misses the point. Nebraska's purpose in enacting LB 23 was not to prevent the killing of a fetus in utero (abortion); rather, its purpose is to prohibit the killing of a child in the birth canal so as to prevent the erosion of the line between abortion and infanticide.

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[16] Professor Singer contends that "the life of a fetus . . . is of no greater value than the life of a nonhuman animal at a similar level of rationality." Singer then "admit[s] that these arguments apply to the newborn baby as much as to the fetus. A week-old baby is not a rational and self-conscious being, and there are many nonhuman animals whose rationality, self-consciousness, awareness, capacity to feel, and so on, exceed that of a human baby a week or a month old." Singer then states that the "widely accepted views about the sanctity of infant life . . . need to be challenged." To support his position in favor of infanticide, Singer reasons that "we should put aside feelings based on the small, helpless, and – sometimes – cute appearance of human infants" whose "helplessness or innocence" should not be preferred to the equally helpless and innocent fetus, "or, for that matter, to laboratory rats who are 'innocent' in exactly the same sense." *Id.* at 169-70.

In *Glucksberg*, this Court recognized the "reasonableness of the widely expressed skepticism about the lack of a principled basis for confining the right [to assisted suicide]." *Glucksberg*, 521 U.S. at 733 n.23 (quoting Brief for United States as Amicus Curiae 26 ("Once a legislature abandons a categorical prohibition against physician assisted suicide, there is no obvious stopping point")); *see also id.* at 785 ("[t]he case for the slippery slope is fairly made out here, . . . because there is a plausible case that the right claimed would not be readily containable") (Souter, J., concurring). Just as Washington's ban on assisted suicide is reasonable because there is no principled basis for confining that "right," so Nebraska's ban on killing a child in the process of birth is reasonable because there would be no principled basis for confining that "right" either.

For example, if a doctor may kill a child whose body has been intentionally delivered into the birth canal except for the head, why may he not also kill a child who has been partially delivered head first? And if he may kill a child who has been partially delivered head first, why may he not kill the child whose entire body is outside of the mother except for one of the child's feet which he holds in the birth canal? And if he may kill a child whose foot or little toe is held in the birth canal, why, then, may the doctor not kill the child who is completely expelled from her mother's body, but still attached to the umbilical cord?

Twenty-seven years ago, this Court could not have anticipated confronting the question now before it. If Nebraska cannot prohibit killing during the process of birth today, then what unimaginable questions will this Court be faced with tomorrow?

CONCLUSION

The court of appeals' judgment should be reversed.

Respectfully submitted,

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February 28, 2000

APPENDICES

A. *Reargument of Roe v. Wade*, October 11, 1972.....App. 1

B. *Declaration of Jack A. Andonie, M.D.* (Oct. 1, 1998).....App. 6

C. *Declaration of Raymond Gasser, Ph.D.* (Oct. 1, 1998).....App. 13

APPENDIX A

Excerpt from the Transcript of the Reargument of Roe v. Wade, 410 U.S. 113 (1973) (Reargued on October 11, 1972). The entire transcript and audio file can be found at http://www.oyez.nwu.edu/support/cases/334/reargument.html

* * *

JUSTICE MARSHALL: Is there any statute in Texas that prohibits the doctor from performing any operation, other than an abortion?

MR. FLOWERS: I don't – I don't think so, sir. And there is another thrust of our argument. If we declare, as the appellees in this case have asked this Court to declare, that an embryo or a fetus is a mass of protoplasm similar to a tumor, then of course the State has no compelling interest whatsoever.

JUSTICE MARSHALL: But there is no – the only operation that a doctor can possibly commit that will bring on a criminal penalty is an abortion?

MR. FLOWERS: Yes, sir.

JUSTICE MARSHALL: Why?

MR. FLOWERS: As far as –

JUSTICE MARSHALL: Well, why don't you limit some other operations?

MR. FLOWERS: Because this is the only type of operation that would take another human life.

JUSTICE MARSHALL: Well, a brain operation could.

MR. FLOWERS: Well, there again that would be – I think that in every feat that a doctor performs that he is constantly making this judgment.

JUSTICE MARSHALL: Well, if a doctor performs a brain operation and does it improperly, he could be guilty of manslaughter, couldn't he?

MR. FLOWERS: I would think so, if he was negligent.

JUSTICE MARSHALL: Well, why wouldn't you charge him with manslaughter if he commits an abortion?

MR. FLOWERS: In effect, Your Honor, we did, in the Statute 1195 that has been very carefully avoided all throughout these proceedings. It's not attacked as unconstitutional, for some reason. If you will permit me to –

JUSTICE MARSHALL: But is it at issue here?

MR. FLOWERS: No, sir. You asked the question about whether we had made manslaughter – or an abortion manslaughter.

JUSTICE MARSHALL: Maybe the reason is: Why have two statutes?

MR. FLOWERS: Well, this was in context with – this is 1195. They are attacking 1191 through 1196, but omitted 1195. Here's what 1195 says – provides: "Whoever shall, during the parturition of the mother, destroy the vitality or life in a child in a state of being born, before actual birth and before actual birth – which child would have otherwise been born alive, which – shall be confined to the penitentiary for life, or not less than five years."

JUSTICE MARSHALL: What does that statute mean?

MR. FLOWERS: Sir?

JUSTICE MARSHALL: What does it mean?

MR. FLOWERS: I would think that –

JUSTICE STEWART: That it is an offense to kill a child in the process of childbirth?

MR. FLOWERS: Yes, sir. It would be immediately before childbirth, or right in the proximity of the child being born.

JUSTICE MARSHALL: Which is not an abortion.

MR. FLOWERS: Which is not – would not be an abortion, yes, sir. You're correct, sir. It would be homicide.

Gentlemen, we feel that the concept of a fetus being within the concept of a person, within the framework of the United States Constitution and the Texas Constitution, is an extremely fundamental thing.

JUSTICE STEWART: Of course, if you're right about that, you can sit down, you've won your case.

MR. FLOWERS: Your Honor –

JUSTICE STEWART: Except insofar as, maybe, the Texas abortion law presently goes too far in allowing abortions.

MR. FLOWERS: Yes, sir. That's exactly right. We feel that this is the only question, really, that this Court has to answer. We have a

JUSTICE WHITE: Do you think the case is over for you? You've lost your case, then, if the fetus or the embryo is not a person? Is that it?

MR. FLOWERS: Yes, sir, I would say so.

JUSTICE WHITE: You mean the State has no interest of its own that it can assert, and

MR. FLOWERS: Oh, we have interests, Your Honor – preventing promiscuity, say, maybe that's

JUSTICE WHITE: Mr. Flowers, your legislature apparently – or you're asserting that your State law wants to protect the life of the fetus?

MR. FLOWERS: Yes, sir.

JUSTICE WHITE: And, under State law, there is some right – there are some rights given to the fetus?

MR. FLOWERS: Yes, sir.

JUSTICE WHITE: And you are asserting those rights, against the right of the mother.

MR. FLOWERS: Balancing against the Ninth Amendment rights of the mother, within the framework

JUSTICE WHITE: But that's wholly aside from whether the fetus is a person under the Federal Constitution. You can still assert those rights, whether the fetus is a person or not.

MR. FLOWERS: Yes, sir.

CHIEF JUSTICE BURGER: Does Texas have judicial statutes on mutilation, making it a criminal act?

MR. FLOWERS: Yes, sir.

CHIEF JUSTICE BURGER: So that there are other assertions

MR. FLOWERS: Yes, sir.

CHIEF JUSTICE BURGER: – or procedures which could be criminal?

MR. FLOWERS: That's right.

CHIEF JUSTICE BURGER: If a man walked into a doctor's office and said, "I want you to cut off my right arm"

MR. FLOWERS: That's right – mutilation, castration – yes, sir. I had forgotten about those, Your Honor.

JUSTICE MARSHALL: Those statutes apply to doctors?

MR. FLOWERS: I would assume so, or anyone that would –

JUSTICE MARSHALL: Do you have any case that says so?

MR. FLOWERS: No, sir. I would say that there would have to be a culpability of proof in there, as in most criminal cases.

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APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

CAUSEWAY MEDICAL SUITE, et al,

PLAINTIFFS **Civil Action**

v.

No. 97-2211 "T"

MURPHY J. FOSTER, JR. Governor
For the State of Louisiana, et al,

DEFENDANTS.

DECLARATION OF JACK A. ANDONIE, M.D.

I, Jack A. Andonie, M.D., declare under the penalty for perjury that the following is true:

1. I am a Clinical Professor in the Department of Obstetrics and Gynecology at LSU Medical School. I am board-certified in obstetrics/gynecology and I am the Founder of Lakeside Women's Specialty Center, Ltd. in Metairie, Louisiana. I received my Medical Degree from LSU Medical School in 1962. I serve as Medical Director at Lakeside Hospital and serve on the current board of the LSU Board of Supervisors. I teach and practice obstetrics-gynecology. I am a licensed medical doctor in the state of Louisiana. A more complete statement of my credentials and training are provided in my attached curriculum vitae. *See Attachment A.*

2. During the course of my thirty-six year medical career in obstetric/gynecology, I have examined and/or

treated approximately twenty thousand women and delivered approximately ten thousand babies. I am a medical expert in the areas of pregnancy, the process of birth, and birth. It is based upon my years of experience as a physician specializing in obstetrics and gynecology, my education, training, and the ongoing study of the relevant medical literature and statistical data normally relied upon by doctors of obstetrics and gynecology in their practices that I offer the following expert opinions.

3. Pursuant to a request by representatives of the Office of the Attorney General for the State of Louisiana, I have reviewed Act 906 of the 1997 Regular Session of the Louisiana Legislature (the "Act"), which creates "the crime of partial-birth abortion" La. R.S. 14:32.9(D). I have been asked to review the Act and offer my expert medical opinion on what the Act proscribes and whether or not a reasonable physician, upon reading the Act, will be sufficiently apprized of what is and what is not permitted under the Act.

4. The Act, with certain detailed exceptions (e.g., the life of the mother), proscribes what it refers to as "partial-birth abortion." The Act defines "partial-birth abortion" as

> the performance of a procedure on a female by a licensed physician or any other person whereby a living fetus or infant is partially delivered or removed from the female's uterus by vaginal means and with specific intent to kill or do great bodily harm is then killed prior to complete delivery or removal. La. R.S. 14:32.9(A)(1).

5. The plain language of the Act proscribes any procedure that is intended to kill an infant in the process

of being born. By its very terms, then, the Act does not include within its proscription any abortion procedure.

6. Induced abortion is one method of terminating a pregnancy, the onset of the birth process is another.

7. Induced abortion is any procedure which causes fetal death *in utero*, thereby causing "the premature expulsion *from the uterus* of the products of conception." *Dorland's Illustrated Medical Dictionary* 4-5 (28th edition 1994) (Dorland's).

8. The process of birth begins, and complete birth is inevitable, once the membranes of the amniotic sac are ruptured, and the infant begins its emergence from the uterus through the cervical os (opening of the uterus) and into the vaginal canal.

9. The delivery or removal of any part of a living fetus from the uterus, beyond the cervical os, and into the vaginal canal after the membranes of the amniotic sac have been ruptured is a significant medical event – an event that is acknowledged under the Act. It is medically significant because pregnancy has ended and the process of birth has begun.

10. Pregnancy describes the locus where intrauterine fetal stasis is maintained. Pregnancy has never occurred or been maintained in the vaginal canal.

11. Because it is a medical fact that pregnancy is over (terminated) once the process of birth has begun, the Act's plain language regulates the birth process, not any abortion procedure. This is made plain because the Act proscribes the intentional killing of a living fetus or infant who has been *partially delivered or removed from the*

female's uterus by vaginal means. In medical terms, the Act does not prohibit those procedures undertaken to terminate *pregnancy*, because the Act's terms address specific intent to kill a living fetus or infant *after* the pregnancy has already been terminated.

12. Where the Act describes a "living fetus or infant [that] is partially delivered or removed from the female's uterus by vaginal means" it has, thereby, given effect to the medical distinction between (1) the locale where intrauterine fetal stasis is maintained (i.e., pregnancy) and (2) the dynamic irreversible process of birth. "Birth" is a process, not a single event. The birth process *begins* when the membranes of the amniotic sac are ruptured and the fetus emerges beyond the cervix into the vaginal canal, and *ends* with the complete separation from the mother.

13. By its own terms, then, the Act clearly regulates the process of birth which begins when the living fetus begins to exit the womb as described above. (The terms womb and uterus are synonymous. Dorlands at 1846 ("womb" is defined as "the uterus")).

14. The Act's plain language proscribes only those procedures wherein a living fetus (infant) is partially delivered or removed into the vaginal canal itself. A fetus or fetal part suctioned out through an enclosed vacuum tube running through the vagina would not, in medical terminology, be characterized as a fetus who is "partially delivered or removed from the female's uterus by vaginal means."

15. There is no question that the Act *does not* proscribe the destruction of a fetus *in utero*, i.e. abortion,

because by its very terms the Act proscribes only those procedures designed to kill an infant that has been partially delivered out of the uterus at which point pregnancy has ended, the process of birth has begun, and abortion is no longer a medical possibility.

16. Though the term "partial-birth abortion" is not a medical term, it is descriptive of a medical procedure(s), as defined by the Act, that is practiced by some abortion doctors who refer to the procedure by various terms including "D&X," "intact dilation and extraction," "intact dilation and evacuation, "intact D&E," and "intact D&X.".

17. Plaintiffs' own description of the "D&X procedure" would clearly qualify as a procedure prohibited by the plain terms of the Act:

> The intact D&E, "D&X," or "intact D&X" procedure is a variant of the traditional D&E procedure. . . . [T]he cervix is gradually dilated and the fetus is removed intact. . . . [T]he physician then creates a small opening at the base of the skull and evacuates some of the contents, allowing the calvarium [now emptied skull] to pass through the cervical opening. Alternatively, once the fetus is partially extracted, the physician crushes the skull with forceps. . . . The intact removal of the fetus is what distinguishes an intact D&E procedure from a traditional D&E procedure. [*Complaint* at ¶ 41.]

18. The Act proscribes doing "great bodily harm . . . " to "a living fetus or infant" that is "partially delivered . . . . " Medically speaking, you can do "great bodily harm" only to an intact "living fetus" or "infant." Therefore, a reasonable medical doctor reading the Act would understand "living fetus" and living "infant" to mean the living fetal (infant) organism as opposed to living fetal cells or dismembered fetal limbs or body parts.

19. Medical science recognizes that the living fetal (infant) organism is living if it shows signs of life, such as beating of the heart, pulsation of the umbilical cord or movement of voluntary muscles.

20. The Act's plain language clearly does not proscribe the cephalocentesis procedure, which is removal of fluid from an enlarged head of a fetus with the most severe form of hydrocephalus. In such a procedure, a needle is inserted into the enlarged ventricle of the brain (the space containing cerebrospinal fluid). Fluid is then withdrawn which results in reduction in the size of the head so that delivery can occur. This procedure is not intended to kill the fetus, and, in fact, is often associated with the birth of a live infant. This is an important distinction between a needle cephalocentesis, which is intended to facilitate the birth of a living fetus, and the procedure described in the Act, which involves specific intent to kill a living fetus which has been partially delivered.

22. Upon reading the Act, a reasonable physician will certainly understand that destruction of the fetus *in utero*, i.e., abortion, remains protected in the law, and that the only procedure prohibited is partial delivery or removal of a living fetus or infant into the vaginal canal for the purpose of pausing the birth process to carry out a second step of intentionally killing the infant prior to complete delivery or removal.

I affirm under the penalties of perjury that the statements in my Declaration are true.

10/1/1998 /s/ Jack A. Andonie
Date Jack A. Andonie, M.D.

Expert Witness Disclosure Required by Fed. R. Civ. P. 26(a)(2)(B)

1. The disclosure of my opinions, basis, reasons, data, qualifications are given in the attached affidavit.
2. My list of all publications within the last ten years is provided in the attached curriculum vitae.
3. My compensation is reasonable expenses, but no fee.
4. I have never before testified as an expert at trial or by deposition.

10/1/1998 /s/ Jack A. Andonie
Date Jack A. Andonie, M.D.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF LOUISIANA

CAUSEWAY MEDICAL SUITE, ET Al.,

PLAINTIFFS **Civil Action**

v.

No. 97-2211 "T"

MURPHY J. FOSTER, JR., ET Al.,

DEFENDANTS.

DECLARATION OF RAYMOND GASSER, PH.D.

I, Raymond Gasser, Ph.D., declare under the penalty for perjury that the following is true:

1. I am a Professor in the Department of Cell Biology and Anatomy at LSU Medical School (LSUMC), and, since 1980, I have been the course Director for Human Prenatal Development. I have been an Adjunct Professor of Obstetrics and Gynecology since 1994. I have been a member of the International Anatomical Nomenclature Committee since 1991 and I head the subcommittee on human embryological terms. Since 1991 I have been on the Advisory Committee, Human Developmental Anatomy Center, Armed Forces Institute of Pathology in Washington D.C. Also, since 1991 I have been Adjunct Curator for the Carnegie Collection of Human Embryos, Human Developmental Anatomy Center, Armed Forces Institute of Pathology, Washington D.C. My other credentials and experience are provided in my attached curriculum vitae. *See Attachment A – Curriculum Vitae.*

2. Based on my education, training, research, years of experience as a Professor of Anatomy and Ob/Gyn, personal knowledge, study of the relevant medical literature and statistical data recognized as reliable in the medical profession, I offer the following expert opinions.

3. Pursuant to a request by representatives of the Office of the Attorney General for the State of Louisiana, I have reviewed Act 906 of the 1997 Regular Session of the Louisiana Legislature (the "Act"), which creates "the crime of partial-birth abortion" La. R.S. 14:32.9(D). I have been asked to review the Act and offer my expert opinion on what the Act proscribes and whether or not a reasonable physician, upon reading the Act, will be sufficiently apprized of what is and what is not permitted under the Act.

4. The Act, with certain detailed exceptions (e.g., the life of the mother), proscribes what it refers to as "partial-birth abortion." The Act defines "partial-birth abortion" as

> the performance of a procedure on a female by a licensed physician or any other person whereby a living fetus or infant is partially delivered or removed from the female's uterus by vaginal means and with specific intent to kill or do great bodily harm is then killed prior to complete delivery or removal. La. R.S. 14:32.9(A)(1).

5. The Act is clear, in medical/anatomical terms, about the location of the "living fetus or infant" that cannot, with specific intent, be killed.

6. The clarity of the Act is manifest because by its very terms it describes a living fetus or infant who is in the process of being born.

7. A living fetus or infant is in the process of being born when he or she begins to emerge from the uterus through the cervical os into the vaginal canal, which occurrence denotes the medical fact that the inevitable and unstoppable process of birth has begun.

8. Because the Act addresses a procedure that involves specific intent to kill a living fetus or infant who has been intentionally partially removed from the uterus into the vaginal canal, the Act regulates the process of birth, not the induced abortion of an unborn fetus.

9. Induced abortion is one method of terminating a pregnancy, the onset of the birth process is another.

10. The significant medical distinction between pregnancy and the process of birth is best made by describing the anatomical structure of the woman with reference to the locus of the living fetus within that structure: *See Exhib. D-5, "Uterus, Vagina and Supporting Structures."*

a. The uterus is the muscular organ in a female in which a developing embryo and fetus is nourished.

b. The cervix is the neck of the uterus which opens into the vagina. The cervical os is the opening of the cervix.

c. The amniotic sac is the protective membrane between the cervical os and the vaginal canal.

d. The vagina is the canal in the female, extending from the vulva to the cervix.

As long as the fetus remains within the uterus a woman is pregnant. When, however, the membranes of the amniotic sac have been ruptured and any part of the living fetus or infant is delivered through the cervix, past the cervical os and into the vaginal canal, pregnancy has ended and the process of birth has begun.

11. The medical/anatomical distinction between pregnancy and the process of birth is underscored by the fact that pregnancy has never occurred or been maintained in the vaginal canal.

12. "Fetus" is the medical term to describe "the *unborn* offspring in the postembryonic period, after major structures have been outlined, in humans from nine weeks after fertilization until birth." DORLAND'S *ILLUSTRATED* MEDICAL DICTIONARY 617 (28th Ed. 1994). The term "fetus" means only the unborn child, not the umbilical cord or the placenta, although those structures are of fetal origin. *See Exhibit D-6, Lennart Nilsson photograph.*

14. Where the Act speaks of a "living fetus or infant that is partially *delivered or removed from the female's uterus by vaginal means"* it can, of medical/anatomical necessity, only mean that the living fetus or infant is removed from the uterus into the vaginal canal and does not include the suction of a fetus or fetal parts "into an enclosed suction cannula [tube]" running through the vagina.

15. In medical terms *fetus* means preborn human offspring 9 weeks after conception, and is expressly defined in the Act as meaning "the biological offspring of human parents."

16. *Infant*, as expressly defined in the Act means "the biological offspring of human parents." *Infant* is defined as " . . . human young from birth to 12 months; it includes the newborn or neonatal period." DORLAND'S *ILLUSTRATED* MEDICAL DICTIONARY 836 (28th Ed. 1994).

17. The Act proscribes doing "great bodily harm . . . " to "a living fetus or infant" that is "partially delivered . . . . " Medically/anatomically speaking, you can do "great bodily harm" only to an intact "living fetus" or "infant." Therefore, a reasonable medical doctor reading the Act would understand "living fetus" and living "infant" to mean the living fetal (infant) organism as opposed to living fetal cells or dismembered fetal limbs or body parts.

18. The fetal/infant organism is living if it shows signs of life, such as beating of the heart, pulsation of the umbilical cord or movement of voluntary muscles.

19. I have reviewed the artist's illustration that was used by Dr. Jack Andonie to explain partial birth abortion to the Louisiana House and Senate committees considering the Act at issue (a copy of which is attached hereto as *"Attachment B"*). It is my expert opinion that the illustration accurately depicts a baby 8-10 inches long, measured to scale to the doctor's hand. This corresponds exactly to the size of a baby during the 20-24 week range of pregnancy. Thus, the illustration accurately depicts the anatomical structures of the fetus, then partially born infant and female as described by Dr. Haskell in his 1992 paper entitled "Dilation and Extraction for Late Second Trimester Abortion." [*See* Defendants' Exhibit D-2].

20. Plaintiffs' own description of the "D&X procedure" mirrors the illustration described in paragraph 19 above and would clearly qualify as a procedure prohibited by the plain terms of the Act:

> The intact D&E, "D&X," or "intact D&X" procedure is a variant of the traditional D&E procedure. . . . [T]he cervix is gradually dilated and the fetus is removed intact. . . . [T]he physician then creates a small opening at the base of the skull and evacuates some of the contents, allowing the calvarium [now emptied skull] to pass through the cervical opening. Alternatively, once the fetus is partially extracted, the physician crushes the skull with forceps. . . . The intact removal of the fetus is what distinguishes an intact D&E procedure from a traditional D&E procedure. [*Complaint* at ¶ 41.]

21. A reasonable person reading the Act will have no doubt that he/she is prohibited only from intentionally killing a living fetus or infant that has been partially delivered into the vaginal canal.

I affirm under the penalties of perjury that the statements in my *Declaration* are true.

10/1/1998 /s/ Raymond Gasser
Date Raymond Gasser, Ph.D.

Expert Witness Disclosure Required by Fed. R. Civ. P. 26(a)(2)(B)

1. The disclosure of my opinions, basis, reasons, data, qualifications are given in the attached affidavit.
2. My list of all publications within the last ten years is provided in the attached curriculum vitae.
3. My compensation is reasonable expenses, but no fee.
4. I have testified as an expert at trial or by deposition in the following:

10/1/1998 /s/ Raymond Gasser
Date Raymond Gasser, Ph.D.

Feb 25 2000

(14)

No. 99-830

Supreme Court, U.S.
FILED
FEB 25 2000
CLERK

In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF OF THE STATE OF WISCONSIN AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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QUESTIONS PRESENTED

I. Whether the Eighth Circuit's adoption of a broad unconstitutional reading of Nebraska's ban on partial-birth abortion, which directly conflicts with the narrower constitutional construction of similar statutes by the Seventh Circuit Court of Appeals and that of the State officials charged with enforcement of the statute, violates fundamental rules of statutory construction and basic principles of federalism in contradiction of the clear direction of this Court in *Webster v. Reproductive Health Services*?

II. Whether the Eighth Circuit misapplied this Court's instructions in *Planned Parenthood v. Casey* by finding that a law banning cruel and unusual methods of killing a partially-born child, is an "undue burden" on the right to abortion?

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BRIEF OF THE STATE OF WISCONSIN AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Supreme Court Rule 37, the State of Wisconsin submits this brief as *amicus curiae* in support of petitioners.

STATEMENT OF INTEREST OF *AMICUS CURIAE*

The State of Wisconsin has a strong interest in the Court's construction of Nebraska's statute limiting partial-birth abortions, the Court's consideration of federalism principles as they relate to partial-birth abortion statutes, and the Court's application of the "undue burden" test of *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), to partial-birth

abortion statutes, because the State of Wisconsin enacted a partial-birth abortion statute that has withstood a challenge at the district court and court of appeals levels when construed in accordance with the Wisconsin Legislature's intent. Wisconsin's partial-birth abortion statute was enacted to limit only one rare method of abortion, known medically as "D&X" (dilation and extraction), while other alternative methods remain available.

The State of Wisconsin has an interest in presenting to this Court a partial-birth abortion statute with language different from Nebraska's statute, and a trial record that includes the testimony of the abortion providers themselves showing that partial-birth abortion statutes are not vague to them and can be enforced without posing an undue burden on women seeking abortions.

SUMMARY OF ARGUMENT

While women have a constitutional right to have abortions, they do not have a constitutional right to a particular type of abortion that a State legislature has determined is less safe than other available methods and offends the public morality.

The evidence introduced at trial in *Planned Parenthood v. Doyle*, 44 F. Supp.2d 975 (W.D. Wis. 1999), *vacated and remanded sub nom. Hope Clinic v. Ryan*, 195 F.3d 857 (7th Cir. 1999) (en banc), showed that the medical community, including plaintiff abortion providers and their experts, knows what a partial-birth abortion is when they are practicing medicine outside of the courtroom. The documentary and testamentary evidence revealed that only one method of abortion fits the Wisconsin statute's definition of partial-birth abortion, and that is known by the medical term D&X (dilation and extraction) abortion. Contrary to the conclusion of the Eighth Circuit in this case, a D&E (dilation

and evacuation) abortion does not fall within the definition of partial-birth abortion.

The State of Wisconsin was able to show that it has interests in maternal health, potential life and morality that are furthered by the enactment of Wisconsin's partial-birth abortion statute. The evidence illustrated that while the D&X method of abortion may have some theoretical benefits over other methods of abortion, those theories have not yet been borne out by results. The evidence was clear that all the testifying physicians who held hospital privileges preferred the induction method of abortion at the gestational ages when D&X abortions are performed (twenty to twenty-four weeks), even if they declared that there are theoretical benefits to D&X abortions. Physicians without hospital privileges indicated that the biggest factor in determining whether to use the D&X or D&E method of abortion was whether after two days of dilation a D&E could be performed safely and thereby the woman could avoid the "inconvenience" of having to return a third day when there would be more dilation and a D&X abortion could be performed.

The evidence presented at the trial in Wisconsin showed that a D&X abortion is never the only safe option for a woman seeking an abortion. Plaintiffs were unable to present any evidence of a situation where a partial-birth abortion was necessary to preserve the health of a pregnant woman.

States' partial-birth abortion statutes do not have the purpose or effect of imposing an undue burden on women seeking abortions, but intend only to limit the availability of one rare method of abortion that comes close to infanticide. Despite the fact that respondents' counsel in this case have been involved in litigation over States' partial-birth abortion statutes around the country, they were unable to show that the Wisconsin partial-birth abortion statute had the effect of placing a substantial obstacle in the path of women seeking abortions. During the period of time Wisconsin's statute was

in effect the physicians continued to provide abortions to pregnant women at all weeks of gestation. No physician reported an increase in morbidity/mortality rates while the statute was in effect.

The record in *Planned Parenthood v. Doyle* showed that a partial-birth abortion statute can be construed to apply only to the D&X method of abortion and under such construction is not an undue burden on women seeking abortions, an issue never reached by the Eighth Circuit in *Carhart v. Stenberg*, 192 F.3d 1142 (8th Cir. 1999).

The decision below should be reversed.

ARGUMENT

I. THE DEFINITIONS OF PARTIAL-BIRTH ABORTION IN STATES' STATUTES ARE NOT UNCONSTITUTIONALLY VAGUE.

A. THE DOCUMENTARY EVIDENCE AND THE TESTIMONY OF PLAINTIFF ABORTION PROVIDERS SHOWS THAT THEY KNOW WHAT A PARTIAL-BIRTH ABORTION IS UNDER VARIOUS STATES' STATUTES.

The definitions of partial-birth abortion in States' partial-birth abortion statutes use commonly understood terms

to describe the method of abortion they seek to limit.[1] Wisconsin's statute, like many other States', requires that a child first be intentionally partially vaginally delivered, then intentionally killed, then fully delivered. Wis. Stat. § 940.16.

On the witness stand, several Wisconsin plaintiff physicians admitted they understood the meaning of the terms used in Wisconsin's statute and agreed that the statute required three acts in sequence. The medical term for a partial-birth abortion is a D&X abortion (or intact D&E abortion). Plaintiffs know what a D&X abortion is and do not dispute that it fits the statutory definition. The exhibits introduced at trial illustrate that the medical community, and indeed several of plaintiffs' witnesses themselves, know what a partial-birth abortion is in a context outside of the courtroom.[2]

Plaintiff Dr. Broekhuizen, a professor of Obstetrics and Gynecology at the University of Wisconsin Medical School, was asked "[i]s there any individual term in the definition of a partial-birth abortion that you do not understand" to which he

---

[1] *See, e.g.*, Wis. Stat. § 940.16 Partial-birth abortion. (1) In this section:

(a) "Child" means a human being from the time of fertilization until it is completely delivered from a pregnant woman.

(b) "Partial-birth abortion" means an abortion in which a person partially vaginally delivers a living child, causes the death of the partially delivered child with the intent to kill the child, and then completes the delivery of the child.

(2) Except as provided in sub. (3), whoever intentionally performs a partial-birth abortion is guilty of a Class A felony.

(3) Subsection (2) does not apply if the partial-birth abortion is necessary to save the life of a woman whose life is endangered by a physical disorder, physical illness or physical injury, including a life-endangering physical disorder, physical illness or physical injury caused by or arising from the pregnancy itself, and if no other medical procedure would suffice for that purpose.

[2] "Both medical and popular literature equate 'partial-birth abortion' (the statutory term) with the D&X procedure." *Hope Clinic v. Ryan*, 195 F.3d at 865 (citations omitted).

answered "[n]o, I understand that in layman's term, yeah, that that—I understand every term that's being written down here" (Tr. 115[3]). Plaintiff Dr. Jacobson "can understand individually each term in the definition of 'partial-birth abortion' in Wis. Stat. § 940.16" (Stip. ¶ 102).

Plaintiff Christensen issued a press release on May 21, 1998, after initiating the Wisconsin lawsuit, that admits that he knows exactly what procedure the statute is limiting:

> After carefully weighing the medical needs of my patients, the personal legal risks and the political consequences relative to the public abortion debate, I have decided to resume providing a full range of abortion services through the 24th menstrual week of pregnancy. In order to avoid prosecution under the so called "partial birth" abortion law I have been forced to alter the surgical technique, with the consent of the patient, so that procedure will not fall within the scope of the law even if the change results in a sub-optimal procedure which increases the risks.

(Ex. 208).

Plaintiffs' expert (in both this case and the Wisconsin case), Dr. Phillip Stubblefield, agreed with the statement written by David Grimes, M.D., (described by Stubblefield as an expert in the field of abortion), that "some federal and state legislators have attempted to ban intact D&E" (referring to Ex. 207). Dr. Stubblefield himself wrote a chapter for an OB/GYN

[3] Citations to "Tr." are to the transcript of the May 27, 1999, trial before the district court in Wisconsin, to "Ex." are to exhibits entered into evidence at that trial, to "Stip." are to the parties' Amended Joint Pretrial Stipulation of Facts, and to "Stubblefield Tr." are to the trial testimony of Dr. Stubblefield given by deposition on May 7, 1999.

medical textbook providing "[t]he breech extraction variation of intact D & E, described in the lay press as 'partial birth abortion' has been made illegal in several states" (Ex. 239). Dr. Stubblefield replied in the affirmative to the question "[w]ould you agree with the statement that some members of the medical community refer to D&X as partial birth abortion" (Stubblefield Tr. 92).

Plaintiffs' expert Dr. Martin Haskell (who pioneered the D&X method) replied "[s]ure. Yes." to the question whether he would agree with the statement that "some federal and state legislators have attempted to ban intact D&E" (Tr. 41). Dr. Haskell even wrote a letter to Congressman Canady at the time of the federal deliberations on partial-birth abortion in which he indicated he knew exactly what method of abortion was being referred to as partial-birth abortion:

> Recently, your committee held a hearing regarding a procedure that you refer to as a partial birth abortion.
>
> . . . .
>
> [T]he original paper is over three years old. The procedure has continued to evolve in refinement since then. Statements that fetuses are not dead until nearly the end of the procedure are not accurate. Death occurs early in the procedure if not before. Representations that fetuses are living, conscious, feeling pain, wiggling, kicking or trying to escape are totally fictitious.

(Ex. 202 at 24-25).

The expert retained by the State of Wisconsin, Dr. Harlan Giles,[4] testified on cross-examination that he and the rest of the informed medical community know what partial-birth abortion means:

> Q Is it your understanding that the term partial-birth abortion has some commonly understood meaning within the medical community?
>
> A I think the medical community has come to understand that term in the last few years. I don't think it was something that appeared anywhere in our literature until just very recently.
>
> Q But you think there's some sort of a relative consensus now about what that term means in the medical community?
>
> A I would think so.
>
> Q What is that? What is the meaning of partial-birth abortion that is—that there's consensus about in the medical community?
>
> A That in the process of terminating the pregnancy that a portion of the fetus is delivered into the vagina and then a

[4] Dr. Giles testified as an expert in obstetrics, gynecology, maternal fetal medicine, abortion procedures and prenatal genetics. Dr. Giles is a professor and associate dean of medical education at the Medical College of Pennsylvania and Hahnemann University, Allegheny University of Health Sciences. Dr. Giles is also a clinical professor in the Department of Obstetrics and Gynecology at the University of West Virginia School of Medicine. Dr. Giles is a fellow of the American College of Obstetricians and Gynecologists (ACOG).

> specific procedure is undertaken that will kill the fetus prior to completing the delivery.
>
> Q And is it your impression that the term D&X is also widely understood to have a single meaning within the medical community?
>
> A In a general way, yes, I think so.
>
> Q And what is that meaning?
>
> A Pretty much the same meaning I gave to partial-birth abortion; that is, delivering a portion of the fetus into the vagina and specifically carrying out a procedure such as evacuating the brain contents or cutting the umbilical cord which has the express purpose of killing the fetus before completing the delivery.

(Tr. 209-10).

The literature of the medical community has recognized that the partial-birth abortion debate refers to D&X abortions (sometimes called intact D&E abortions), although some of the publications post-date the trial in *Carhart v. Stenberg* (*see, e.g.,* Ex. 240, Annas, "Partial-Birth Abortion, Congress, and the Constitution," *Legal Issues in Medicine*[5]). Introduced into evidence at the trial in Wisconsin was an article by Stanley Henshaw of the Alan Guttmacher Institute, described by plaintiffs as an institute that does "a lot of demographic and surveillance studies about abortion" (Tr. 41), in which Henshaw states that the "medically accepted term

[5] This article was published in Vol. 339, No. 4 on July 23, 1998, after the March 24, 1998 trial in *Carhart v. Stenberg*.

intact dilatation and extraction D&X as defined by the ACOG is the only procedure that approximates the various descriptions of partial-birth abortion" (Tr. 41; Ex. 230 at 269).[6] The Journal of the American Medical Association (JAMA) itself published a symposium of articles on the subject, making it clear that partial-birth abortion legislation is directed at the D&X abortion method (*see* Exs. 205-07).[7]

The American College of Obstetricians and Gynecologists ("ACOG") concluded that "the intent of such legislative proposals [limiting partial-birth abortions] is to prohibit a procedure referred to as 'Intact Dilatation and Extraction' (Intact D & X)" (Ex. 16). Similarly, the American Medical Association understands what procedure is subject to the statutes at issue:

> The term "partial birth abortion" is not a medical term. The American Medical Association will use the term "intact dilatation and extraction" (or intact D&X) to refer to a specific procedure comprised of the following elements: [then delineating the same steps described by the ACOG]. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester.

Rpt. of the Bd. of Trustees on Late-Term Pregnancy Termination Techniques, May 1997 (Ex. 17). The AMA Report specifically distinguishes the D&X method of abortion from other methods saying "[o]ne feature that distinguishes the D&X procedure from other destructive procedures is that the

---

[6] "Abortion Incidence and Services in the United States, 1995-1996," published Nov./Dec. 1998, after the March 24, 1998, trial in *Carhart v. Stenberg*.

[7] This symposium of articles was published in JAMA, Vol. 280, August 26, 1998, after the March 24, 1998, trial in *Carhart v. Stenberg*.

fetus may be partly outside the woman's body" (Ex. 17). Plaintiff Broekhuizen stated that he "agree[d] with that statement" (Tr. 120).

In short, the medical community, including plaintiff physicians, knows that the challenged partial-birth abortion statutes limit the method of abortion known to physicians as D&X (or intact D&E). "Indeed, the district court in Wisconsin found as a matter of fact that physicians who are likely to perform an abortion already understand that this [D&X] is the point of partial-birth abortion statutes. 44 F. Supp.2d at 978. That finding cannot be set aside as clearly erroneous." *Hope Clinic v. Ryan*, 195 F.3d at 868.

B. THE D&X METHOD OF ABORTION IS DISTINCT FROM THE D&E METHOD: ONLY IN THE D&X METHOD DO PHYSICIANS INTENTIONALLY KILL AN INTACT CHILD WHILE IT IS IN THE VAGINAL CANAL.

The Eighth Circuit in this case found that the definition of partial-birth abortion in Nebraska's statute would apply not only to D&X abortions, but also to D&E abortions, and therefore held Nebraska's statute unconstitutional. However, as plaintiffs described the various abortion methods in the Wisconsin litigation, it was clear that only in the D&X method does the physician intend to kill the child at a certain point, *i.e.* while in the vaginal canal, and intend to complete delivery of the intact child. In all other methods plaintiffs described (D&E, induction, suction curettage/vacuum aspiration), the

child's death occurs at different times and from different causes.[8]

In contrast to plaintiffs' definition of a D&X (or intact D&E) abortion[9], plaintiffs' definition a D&X abortion describes the partial delivery of an intact child, an act done by a physician while the child is partially delivered that will kill the intact child, and then the completion of the delivery of the intact child:

> In the intact D&E procedure (which is also known as "dilation and extraction," "D&X" or "intact D&X"), the physician dilates the cervix and then removes the fetus from the uterus through the vaginal canal *intact*. The physician extracts the fetal body *intact*, usually feet first, until the cervix is obstructed by the aftercoming head, which is too large to pass through the cervix. Then the physician creates a small opening at the base of the skull and evacuates the contents, allowing the calvarium to pass through the cervical opening. *The intentional*

[8] The Seventh Circuit described the uniqueness of the D&X method of abortion: "Central to the D&X procedure [is] that an intact fetus moves from uterus to vagina before death occurs." *Hope Clinic v. Ryan*, 195 F.3d at 863. "It is this combination of coming so close to delivering a live child with the death of the fetus by reducing the size of the skull that not only distinguishes D&X from D&E medically but also causes the adverse public (and legislative) reaction." *Id.* at 862.

[9] "The most common method of second-trimester abortion is the dilation and evacuation (D&E) procedure" (Stip. ¶ 35). "In a D&E procedure, the physician generally dilates the cervix by inserting laminaria (an osmotic dilator placed in the woman's cervix, which absorbs natural moisture and expands, dilating the cervix)" (Stip. ¶ 36). The laminaria remain in overnight. After the laminaria are removed, the physician will use a vacuum curette to rupture the membranes (amniotic sac) (*id.*). The physician will use forceps to grasp and remove the remainder of the child from the uterus (Stip. ¶ 37). The D&E usually involves dismemberment of the child and repeated insertions of the forceps into the uterus (Stip. ¶ 37).

> *removal of the fetus intact is what distinguishes an intact D&E procedure from a D&E procedure.*

(Stip. ¶ 65; Christensen Decl. ¶ 9; Smith Decl. ¶ 9 (emphasis added).) Plaintiffs' expert Dr. Stubblefield agreed with the statement that "the D&X procedure is distinct from the D&E procedure" (Stubblefield Tr. 98). He indicated the "goal" of a D&X "is to modify the D&E procedure in a way that the fetus is delivered essentially intact rather than dismembered into pieces" (Stubblefield Tr. 9).

The practitioner who coined the term "Dilation and Extraction or D&X" did so to distinguish it from "dismemberment-type D&E's." (Ex. 204, Haskell "Dilation and Extraction for Late Second Trimester Abortions.") Dr. Stubblefield agreed with the statement in Dr. Haskell's paper that "[t]he surgical method described in this paper differs from classic D&E in that it does not rely upon dismemberment to remove the fetus" (Stubblefield Tr. 90).

Plaintiffs specifically distinguish the D&E from the D&X by the element of intent, and Wisconsin's statute does the same by requiring the intentional performance of a partial-birth abortion. Wis. Stat. § 940.16(2). The scienter requirement of partial-birth abortion statutes ensures that the statutes are not unconstitutionally vague. Contrasting plaintiffs' definitions of D&E abortions to their definition of D&X abortions, it becomes clear that only in performing D&X abortions do physicians *intentionally* partially deliver a *living* child or are "practically certain" to do so.

The Attorneys General of Wisconsin and Illinois stipulated that under their respective States' laws "a procedure may be deemed a 'partial-birth abortion' only if at the outset of the procedure the physician intends to perform all of the steps that mark the D&X." *Hope Clinic v. Ryan*, 195 F.3d at 867. By contrast, the Eighth Circuit found in this case that "[a]

physician need not set out with the intent to perform a D&X procedure in order to violate the statute. It is enough that the physician have the intent to deliver vaginally a substantial portion of a living fetus, and that occurs in the D&E procedure." *Carhart v. Stenberg*, 192 F.3d at 1150.

Plaintiffs in the Wisconsin case claimed that the phrase "partially vaginally delivers a living child" is vague because it does not distinguish between situations where a fetal part is delivered into the birth canal and situations where a portion of an intact fetus is delivered into the birth canal (*see, e.g.*, Christensen Decl. ¶ 17 (Ex. 214)) (Similar claims were made in this case. *Carhart v. Stenberg*, 192 F.3d at 1150[10]). Interpreting "partially" to include dismembered parts of a child ignores that the definition of "partial-birth abortion" continues after the challenged phrase: "'Partial-birth abortion' means an abortion in which a person partially vaginally delivers a living child, causes the death of the partially delivered child with the intent to kill the child, and then completes the delivery of the child." Wis. Stat. § 940.16(1)(b). The "*living* child" phrase tells the doctor that a dismembered part of a body of a child that may wind up in the vaginal canal is not part of the relevant definition. Furthermore, the deliberate causing of the death to the partially delivered child would indicate that a dismembered part of a child is not within the scope of the language because

[10] Nebraska's statute prohibits a person from "'deliberately and intentionally delivering into the vagina a living unborn child, *or a substantial portion thereof*, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.' Neb. Rev. Stat. § 28-326(9) (1998)." *Carhart v. Stenberg*, 192 F.3d at 1150 (emphasis added). The Eighth Circuit held that "[t]he *crucial* problem is the term 'substantial portion'" and found that an arm or a leg is "substantial." *Id.* (emphasis added).

Wisconsin's statute does not contain the "substantial portion" language that troubled the Eighth Circuit. *See* Wis. Stat. § 940.16(1)(b). The Wisconsin statute requires the delivery of an intact body into the vagina. Wis. Stat. § 940.16(1)(b).

no doctor could reasonably claim that he causes the death of a dismembered part of a child. *See Planned Parenthood v. Doyle*, 44 F. Supp.2d at 985. The final act, completing delivery of the *child*, could not be done if the physician were just completing delivery of a dismembered part of a fetus.

For a D&E to fall within the definition of a partial-birth abortion in Wis. Stat. § 940.16(1)(b), courts would have to read the term "partially vaginally delivers a living child" to include the removal of dismembered parts of the fetus, and would have to equate the performance of any abortion with "causes the death of the partially delivered child with the intent to kill the child."

The Wisconsin statute's required sequencing of events—that the intentional killing follow the partial delivery and precede the completion of delivery of the child—further clarifies that D&Es are not contemplated by the statute. In performing D&E abortions a physician is not "practically certain" that he will cause the death of a partially delivered child. Plaintiff Dr. Broekhuizen testified that when he begins a D&E procedure he does not know at what point he will kill the child (Tr. 122). Similarly, plaintiff Drs. Christensen and Smith submitted affidavits indicating they do not know at what point a child dies during their performance of D&E abortions (Christensen Decl. ¶ 8 (Ex. 214); Smith Decl. ¶ 8 (Ex. 219)).

Dr. Stubblefield testified for plaintiffs that when a doctor begins a D&E procedure he does not know when the child will die (Stubblefield Tr. 70). Dr. Stubblefield testified about D&Es that "detaching a limb, that's going to cause bleeding, but it's not going to immediately kill the fetus. . . . Evulsing one limb may not result in the death of the fetus for awhile. Perhaps evulsing the second limb will result in the death of the fetus sooner" (Stubblefield Tr. 45-46). By contrast, Dr. Stubblefield testified that in a D&X there is a step one takes that he knows will kill the child (Stubblefield Tr.

114)—the child will "certainly die when the skull is crushed" (Stubblefield Tr. 46).

> When a physician employs the "D&X" (by any definition), fetal cardiac activity and other signs of fetal life may continue after the fetus has been extracted intact up to the skull and before the skull is punctured or crushed. Under these circumstances, all fetal cardiac activity and all other signs of life eventually cease as a result of the steps the physician takes to crush the skull or evacuate the contents of the skull.

(Stip. ¶ 67). Dr. Broekhuizen testified for plaintiffs that if the child is alive at the point of decompression of the head in the D&X procedure then the decompression will certainly kill the child (Tr. 123).

Dr. Giles testified:

Q In a D&E abortion does a physician ever intentionally partially deliver a living child into the vagina for purposes of there performing a procedure to kill the child?

A No.

Q In a D&E abortion where does the dismemberment of the child take place?

A Inside the uterine cavity in almost all instances.

Q In a D&E abortion can you predict or control when the death of the child will occur?

A No. In a D&E abortion there is no way in which one would predict or control the timing of the fetal demise.

Q Is there a specific point in a D&E abortion when a child dies?

A No, and in fact a fetus can be delivered with an intact D&E as I've described it and still be alive with cardiac activity after the delivery.

(Tr. 193-94.)

In contrast to the other abortion procedures, Dr. Giles testified that the D&X procedure meets the intentional description of Wis. Stat. § 940.16:

Q In a D&X procedure can you predict or control when the death of the child will occur?

A Yes.

(Tr. 198.)

In sum, plaintiffs' definition of D&X abortions, when contrasted with plaintiffs' definition of D&E abortions, makes clear that the definition of partial-birth abortion in Wis. Stat. § 940.16 is not vague and does not include the common, conventional D&E abortions. Wisconsin Stat. § 940.16 did not criminalize the happenstance of a child dying in the birth canal.

II. LIMITING THE AVAILABILITY OF THE PARTIAL-BIRTH METHOD OF ABORTION TO CIRCUMSTANCES WHERE NECESSARY TO PRESERVE A WOMAN'S LIFE IS NOT AN "UNDUE BURDEN."

States have a "profound interest in potential life." *Planned Parenthood v. Casey*, 505 U.S. at 878. States have "legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child." *Id.* at 846. States "may enact regulations to further the health or safety of a woman seeking an abortion. Unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right." *Id.* at 878.

Under this analysis the undue burden test as applied to partial-birth abortion regulations would inquire: (1) whether the States' statutes are reasonably related to a legitimate state interest or whether the statutes have the purpose of placing a substantial obstacle in the path of a woman seeking an abortion; and (2) whether the States' statutes have the effect of placing a substantial obstacle in the path of a woman in seeking an abortion. The Eighth Circuit in this case did not reach the issue of whether it is an undue burden to limit the availability of one method of abortion when other equally safe or safer methods are still available because it read Nebraska's partial-birth abortion statute to limit D&Es as well as D&Xs.

A. THE D&X METHOD OF ABORTION IS NO SAFER THAN OTHER AVAILABLE ALTERNATIVES. TESTIMONY OF THE ABORTION PROVIDERS SHOWED THAT THERE ARE ALWAYS EQUALLY SAFE OR SAFER ALTERNATIVES TO PARTIAL-BIRTH ABORTIONS, WHICH THEY THEMSELVES REGULARLY USE.

States' partial-birth abortion statutes have been challenged on the grounds that they do not promote maternal health because the D&X abortion method, which the statutes limit, is safer than the classic D&E abortion method. However, testimony at trial in Wisconsin proved that the D&X procedure the Wisconsin Legislature limited is not safer than other abortion procedures available to women. Plaintiffs' and their experts' medical practices did not support their claim that the D&X abortion method was safer than other available methods. The Wisconsin plaintiff physicians who are qualified and providing a full range of OB/GYN services are doing *induction* abortions and those who only perform abortions are doing D&E abortions with rare exceptions.

The testimony of Dr. Stubblefield (plaintiffs' expert in both the Wisconsin case and this one), showed that the safety of the D&X method was only theoretical. Dr. Stubblefield offered only qualified, equivocal support for a procedure that he does not employ. Dr. Stubblefield could not state that it was a medically accepted fact that D&X abortion was safer than other available procedures (Stubblefield Tr. 96). Dr. Stubblefield testified that his "feeling" is that from twenty to twenty-four weeks D&X is safer than D&E. "So that I think in general it may turn out to be a safer way to provide abortion at that gestational age" (Stubblefield Tr. 18). *See also id.* at 20 (D&X "would appear to offer some distinct advantages"). Stubblefield candidly admitted that D&X is at an "early stage"

of the "progress of science in clinical medicine" and eventually it may emerge as an improved procedure (Stubblefield Tr. 26). Stubblefield testified that to be "really clear" on advantages of D&X the "next step of actually comparing [D&E and D&X], preferably in a random basis in the same center" would have to be taken (Stubblefield Tr. 26-27).

Dr. Stubblefield "can recall one occasion when he performed the head-first version of the D&X as he described it," but the fetus was dead when he punctured the skull (Stip. ¶ 82).[11] Dr. Stubblefield "has never performed a D&X on any other occasion" nor has he "seen a D&X performed on any other occasion" (Stip. ¶¶ 83-84). "Dr. Stubblefield has never offered a D&X abortion to one of his patients as an option," nor has he ever "referred a patient to another physician to have a D&X abortion performed" (Stip. ¶¶ 85-86). Aside from testimony in partial-birth abortion cases, Dr. Stubblefield has never testified about the safety of a surgical procedure that he never tried (Stubblefield Tr. 97).

Dr. Stubblefield, members of his faculty and residents under his supervision, perform D&E abortions through seventeen weeks gestation and at weeks eighteen to twenty perform induction abortions; they do not perform abortions later than twenty weeks (Stip. ¶ 87). In Dr. Stubblefield's practice they "are getting good enough results with overnight placement of laminaria tents and the amount of dilatation that accomplishes to allow [them] to do standard D&E reasonably expeditiously," (Stubblefield Tr. 41-42), they do not wait the extra day to do the D&X:

> Q So in the medical sense what is the trade-off between increased time for dilatation and access to the D&X procedure?

[11] The abortion did not preserve the woman's health and Dr. Stubblefield performed a hysterectomy the next day (Stubblefield Tr. 30).

> A That in fact is the trade-off. The patient is investing more time prior to the uterine evacuation procedure in order to do a D&X, another day or more spent wearing laminaria to accomplish the additional dilatation in order to have a briefer procedure of uterine evacuation with less need for instrumentation in the uterus.

(Stubblefield Tr. 42). "Since we use D&E only up to 17 weeks, our decision is that it's not worth the additional day for the patient—day or more—to accomplish the amount of dilatation needed for the D&X procedure, so we choose to stick with conventional D&E" (Stubblefield Tr. 75). Dr. Stubblefield is familiar with OB/GYN residency programs around the country and is not aware of any program that is teaching D&X abortions (Stubblefield Tr. 97).

Dr. Stubblefield also testified that at the same week of gestation "the D&X requires greater dilatation" than the D&E (Stubblefield Tr. 72), which supports the Wisconsin district court's conclusion about increased risk of cervical incompetence and increased risk that a woman's membranes may rupture. *Planned Parenthood v. Doyle*, 44 F. Supp.2d at 979.

Dr. McMahon's 1995 report, "Intact D&E: The First Decade," which plaintiffs introduced into evidence, concludes "[i]s intact D&E better than the classical disruptive D&E? It depends upon the circumstances. Late in pregnancy, it may be the preferred method. Additional data is necessary" (Ex. 18 at 24). Dr. Stubblefield agreed that that statement is still true today (Stubblefield Tr. 84). Dr. Stubblefield also stated he agreed with the summary in Dr. Haskell's report that "among its [D&X's] disadvantages are that it . . . requires a high degree of surgical skill, and may not be appropriate for a few patients" (Stubblefield Tr. 91, referring to Ex. 204).

Dr. Stubblefield testified that for gestational age twenty to twenty-four weeks (when D&X abortions are performed) "it's not been possible to say that the D&E is safer than labor induction. They really appear to be about comparable when you talk about major risks" (Stubblefield Tr. 18). There is no basis for concluding that D&X abortions are safer when D&E abortions are available, and even D&Es have not been shown to be safer than induction abortions.

Dr. Stubblefield was asked the following questions and gave the following answers:

> Q If you would take as a hypothetical that the Wisconsin legislature has only limited the D&X method, then would you agree that Wisconsin has attempted to limit a procedure that has not yet been subjected to a formal peer review?
>
> A Yes.

(Stubblefield Tr. 93-94.)

> Q Has the safety of the D&X procedure ever been studied to the point where it is a medically accepted fact that it is a safer abortion method than other available abortion procedures?
>
> A No.

(Stubblefield Tr. 95-96).

"There are no published medically-recognized studies comparing the risks of D&E to D&X" (Stip. ¶ 90). Plaintiff "Dr. Broekhuizen is unaware of any peer-reviewed journal articles on D&X abortions" (Stip. ¶ 109). "Dr. Broekhuizen believes comparisons of the risks of D&E to D&X would be

valuable information," but is "unaware of any head-to-head comparison" (Stip. ¶ 113).

Dr. Broekhuizen testified that the only way we could have the answer to the question of whether the D&X is safer than the D&E is "prospective randomized trial of D&X versus D&E" (Tr. 91). Dr. Broekhuizen said without prospective randomized trials physicians must "rely on the descriptive nature and theories that have been described. But I think there's a potential that . . . could apply that D&X technique actually is safer than a D&E technique" (Tr. 88).

Dr. Broekhuizen admitted the D&X does not have the same track safety record as the D&E yet (Tr. 105) and he personally does inductions after twenty weeks; he does not set out to do D&E or D&X abortions (Tr. 105-06).

Dr. Broekhuizen testified that at the University of Wisconsin Medical School, Milwaukee clinical campus, they teach residents D&E techniques up until sixteen weeks gestation and induction, but they do not teach D&E after sixteen weeks, nor do they teach D&X (Tr. 109). Dr. Broekhuizen admitted that with doing D&Xs from twenty to twenty-four weeks there may be an increased risk for future pregnancy performance or fertility (Tr. 107). He agreed with the JAMA article that provided "[i]n the absence of controlled studies the relative advantages and disadvantages of the procedure in specific circumstances remain unknown" (Ex. 205; *see* Tr. 118).

Plaintiff Christensen testified on direct that the increased time to increase the amount of dilation required for a D&X abortion *increases* the health risks to the mother:

> A Well, there is a tradeoff between how long it takes to get the cervix dilated and how much cervical dilatation you get. . . . And so if we tried to get any

more than three centimeters' dilatation, for example, it may take us two or three days to get the cervix dilated which subjects the woman to more both psychological and potential medical trauma.

(Tr. 168.)

Q Okay. Is it your understanding that the risk to the woman of complications such as infection increases with the amount of time that's spent dilating the cervix with the laminaria?

A I believe that that is a reasonable assumption, that the longer you have a foreign body in the uterus the greater the risk of infection.

(Tr. 176).

Dr. Giles testified that after twenty weeks the induction method becomes safer and safer relative to the D&E method and D&X would carry higher risk than induction methods. (Tr. 199). In comparing the D&E to the D&X Dr. Giles testified:

Q Is it your opinion that the D&X abortion is riskier than the D&E abortion from 20 to 24 weeks of gestation?

A Yes, I do think it is more risky based on the fact that there is required intrauterine manipulation or twisting of the fetus. There is also a sharp instrument inserted, usually scissors, into the base of the skull without perfect visualization, and I think that increases

the risk of cervical or uterine tears or lacerations and an increase, may increase the risk of bleeding as well.

(Tr. 199-200).

Even the American Medical Association and doctors who perform abortions draw a line at the D&X procedure. The Report of the AMA Board of Trustees does not support use of the D&X procedure:

> According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

(Stip. ¶ 80, Ex. 17).

In short, the best evidence supporting the conclusions of the Wisconsin district court and the Seventh Circuit that the State's interest in maternal health is furthered by a statute limiting partial-birth abortions is physician plaintiffs' own testimony and practices; abortion practitioners continue to use the induction and D&E abortion methods that have proven track records on safety. The State of Wisconsin, like many other States, has enacted measures to protect the mother's health, which is constitutional.

B. THERE IS NO UNDUE BURDEN BECAUSE EQUALLY SAFE OR SAFER METHODS ARE ALWAYS AVAILABLE.

The claim that limiting D&X abortions will impose an undue burden on women is not supported by the experience of abortion providers in Wisconsin while Wisconsin's partial-birth abortion statute was in effect. During that time period, all of the plaintiffs continued to provide abortion services to all of their patients. *Planned Parenthood v. Doyle*, 44 F. Supp.2d at 980-81. Plaintiff Dr. Christensen, the only plaintiff who performs D&X abortions on a regular basis in Wisconsin (two to three a year), testified that his "rate of complications from abortions did not go up in a 'statistically significant fashion' while Wis. Stat. § 940.16 was in effect," even though he reported he would have to alter his abortion technique (Stip. ¶ 125). Moreover, as discussed above, there are always equally safe, if not safer, alternatives to the D&X abortion.

As the district court noted, neither the American Medical Association, nor the American College of Obstetricians and Gynecologists could identify a medical situation in which the D&X abortion would be the only appropriate procedure. *See Planned Parenthood v. Doyle*, 44 F. Supp.2d at 980.

Plaintiffs' testimony supported this conclusion. Neither plaintiffs nor their experts had encountered a situation in which a D&X abortion was necessary to preserve the health of a woman. For example, plaintiff Dr. Smith testified at trial:

> Q Have you ever encountered a situation where you thought that that procedure [D&X] might be better for one of your patients than a procedure you do?

> A As of my experience today, no.

(Tr. 148). Plaintiffs' expert Dr. Haskell testified that he has never encountered a situation where a D&X was medically necessary to achieve the desired outcome (Tr. 71).

Dr. Giles testified that he has "delivered fetuses at literally every week of gestational age . . . I've never faced a situation in which the D&X procedure as I understand it would be necessary . . . ." (Tr. 199). Not only would it not be necessary, it would not even be "preferable to other conventional obstetrical techniques." (Tr. 200-01).

Dr. Giles was specifically asked:

> Q Can you conceive of a medical situation where a D&X would be medically beneficial to the woman's health?
>
> A No, I honestly can't, and I've given it a lot of thought.
>
> Q With respect to prenatal genetics is there any advantage to the D&X method of abortion?
>
> A No, it's disadvantageous because following the evacuation of the cranial vault it is no longer possible to study any part of the brain to determine whether there are any malformations of the central nervous system.

(Tr. 202).

Dr. Giles testified that Wisconsin's statute would not be a burden on women in Wisconsin:

> Q If the State of Wisconsin limits the D&X procedure is it doing something harmful to the health of women in Wisconsin?
>
> A No, I don't think that the statute as I read it would have any negative impact on the health care of women in the state of Wisconsin nor their access to abortion services.

(Tr. 207).

Plaintiff Dr. Smith reported that "[i]n general the D&E is considered the safest procedure, especially in comparison to induction" (Stip. ¶ 94). "Physicians with experience always have the option of converting an intact procedure to a dismemberment procedure" (Stip. ¶ 69). Plaintiff Dr. Broekhuizen testified that "D&X is never the only procedure that's available" (Tr. 84).

Based on the testimony elicited at trial, the parties' stipulation and the documentary evidence introduced into the record, there was no showing that limiting the availability of only the D&X method of abortion would pose a substantial obstacle or undue burden for women seeking abortions. Accordingly, if States' partial-birth abortion statutes are read appropriately to limit only the method of abortion that they address, there is no undue burden to women seeking abortions. "[W]hen state law offers many safe options" to women seeking abortions, "the regulation of an additional option does not produce an undue burden." *Hope Clinic v. Ryan* 195 F.3d at 871. The Eighth Circuit did not have the opportunity to reach this conclusion, but based on the record in the Wisconsin case, this is the conclusion this Court should reach.

CONCLUSION

For the reasons stated above, the judgment of the Court of Appeals for the Eighth Circuit should be reversed.

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Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

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BRIEF OF AGUDATH ISRAEL OF AMERICA AS AMICUS CURIAE IN SUPPORT OF THE PETITIONERS

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INTEREST OF THE *AMICUS CURIAE*

Agudath Israel of America, a national Orthodox Jewish organization with constituents throughout the United States, respectfully submits this *amicus curiae* brief, with the

consent of the parties, for one express purpose: to highlight the abiding interest in both the protection of, and societal reverence for, human life upon which Nebraska's partial-birth abortion ban is predicated.

As an organization dedicated to the welfare of a major American faith group and the religiously-sourced values it holds dear, Agudath Israel often takes public positions, both in the courts and the halls of government, on moral issues of the day that manifest themselves in legal and legislative controversies. We view the maintenance of a societal climate that promotes traditional ethical values as essential not only for the flourishing of this country's diverse faith communities, but as well for the morally healthy social fabric on which the future of our Republic depends.

Consistent with this general perspective, Agudath Israel has long opposed the central holding in *Roe v. Wade*, 410 U.S. 113 (1973), that the right to abortion is "fundamental" and thereby protected against governmental abridgement absent a compelling governmental interest. Agudath Israel has articulated its position on this point in two prior *amicus curiae* presentations to this Court: in *Webster v. Reproductive Health Services* (Oct. Term 1988, No. 88-605), and in *Planned Parenthood of Southwestern Pennsylvania v. Casey* (Oct. Term 1991, Nos. 91-744, 91-902).

The case presently before the Court implicates a related but different aspect of the question of termination of fetal life: the issue of what has come to be known as "partial birth abortion." The procedure may be relatively rare, at least as compared to "typical" abortions, but it raises profound moral concerns whose gravity and centrality for our society cannot be overstated. Agudath Israel's position on partial birth abortion is embodied in the following public statement, issued in 1996:

> "Agudath Israel has for many years opposed legalized abortion on demand. Informed by the teaching of Jewish law that fetal life is entitled to significant protection, with termination of pregnancy authorized only under certain extraordinary circumstances, Agudath Israel is of the view that society, through its laws, should promote a social ethic that affirms the supreme value of life. Allowing abortion on demand, in contrast, promotes a social ethic that devalues life.
>
> "This devaluation is most strikingly evident in the context of a partial birth abortion — an abortion in which a living fetus is partially delivered, and then killed prior to completion of the delivery. Indeed, depending on the circumstances, killing a fetus after it has partially emerged from the birth canal may more properly be deemed infanticide than abortion, and Jewish law might not even recognize a "life of the mother" exception that would permit the procedure. It certainly behooves society at large to recognize the enormity of the moral issues surrounding this procedure, and to enact significant – if not absolute – restrictions on its use.
>
> "Accordingly, while Agudath Israel continues to call for even greater legal protections for fetal life, we welcome as at least a minimally appropriate step the enactment of legislation that would generally prohibit the destruction of life through the practice of partial birth abortions.
>
> "The laws of civilized societies reflect and shape the values of those societies. Laws that allow abortion on demand, or the killing of partially delivered fetuses, are harmful not only because they lead to the taking of innocent and defenseless lives, but because they pollute the moral climate all around us. Let ours be a society that protects and cherishes life."

It is to elaborate upon these societal interests that run counter to the legalization of partial birth abortion that we make this submission.

Pursuant to Rule 37.6 of the Rules of this Court, the

undersigned counsel for Agudath Israel represent that they are the sole authors of this brief, and that no person or entity other than Agudath Israel made any monetary contribution toward the preparation or submission of this brief. (Counsel acknowledge the significant assistance of Moshe Klein, a third-year student at the Columbia Law School, in the research and preparation of this brief.)

ARGUMENT

A STATUTORY BAN ON THE "D&X" PROCEDURE DOES NOT IMPOSE AN UNDUE BURDEN ON WOMEN SEEKING ABORTION WHERE IT HAS THE PURPOSE OF PROMOTING THE STATE'S PROFOUND INTEREST IN PROTECTING HUMAN LIFE AND IN HAVING ITS LAWS REFLECT THE SOCIETAL CONSENSUS THAT EXISTS OPPOSING PARTIAL-BIRTH ABORTION

In granting *certiorari*, the Court agreed to decide whether a statute that outlaws the "D&X" procedure places an undue burden -- under the standard announced in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 876 (1992) -- upon a woman seeking to have an abortion.

An important consideration in this inquiry is whether the "D&X" procedure may, at times, be the medically preferable option for a woman undergoing an abortion, in which event a "D&X" ban may constitutionally require an exception for instances where that procedure is necessary to protect the woman's health. In this regard, we proceed on the basis of the holding in *Hope Clinic v. Ryan*, 195 F.3d 857 (7th Cir. 1999), that there is a sufficient factual basis for a legislature to conclude that the above-mentioned procedure is not the best medical option in any identified situation.

An equally crucial factor, however, in determining the constitutionality of a "D&X" prohibition is the nature and scope of the governmental interests expressed by such law. And it is precisely the fundamental nature and broad scope of the state interests underlying such statutes that makes states' exercise of legislative oversight regarding this procedure an entirely proper one. Indeed, upon closer analysis, one can discern several distinct, albeit cognate, interests that states may have in outlawing the use of the "D&X" abortion method.

I.

The Court Has Recognized The Right Of States To Advance Their Interest In Human Life Through Regulations That, Like A "D&X" Ban, Seek To Influence Women Not To Undergo Abortions

We begin by reprising the relevant teachings of *Casey*, *supra*, the Court's most recent comprehensive treatment of the abortion issue. The Court therein noted that although "*Roe v. Wade* was express in its recognition of the State's 'important and legitimate interest in . . . protecting the potentiality of human life,'" the trimester framework fashioned in *Roe* was "incompatible with the recognition that there is a substantial state interest in potential life throughout pregnancy." 505 U.S. at 876. The Court rejected that aspect of *Roe* and subsequent cases which "undervalue[d] the State's interest in the potential life within the woman [by] . . . . treat[ing] all governmental attempts to influence a woman's decision on behalf of the potential life within her as unwarranted." 505 U.S. at 875-76.

Instead, *Casey's* insistence on "the State's profound interest in potential life" led it to formulate an undue burden standard for judicial scrutiny of state abortion regulations. Under that standard, "[r]egulations which do no more than

create a structural mechanism by which the State . . . may express profound respect for the life of the unborn . . . [or that are] designed to persuade her to choose childbirth over abortion" must be upheld so long as they are reasonably related to those goals and do not "place a substantial obstacle in the path of a woman seeking an abortion" of a nonviable fetus. See 505 U.S. at 877-78.

State prohibitions on use of the "D&X" procedure clearly operate to foster "profound respect for the life of the unborn." They further serve to highlight the nature of that and other abortion procedures in a way that may well "persuade [a woman contemplating an abortion] to choose childbirth over abortion." Accordingly, so long as such proscriptions do not unduly burden a woman's right to choose by placing, in specific instances, the medically preferable abortion procedure beyond her reach, they must be upheld as legitimate advancements of the significant interest that states possess in the preservation of fetal life.

While these statutes, due to their focus on one specific method of abortion, may not produce the direct result of saving specific fetal lives, it cannot be gainsaid that their passage has helped highlight in the public's mind the extreme hideousness of the procedure they prohibit. The enactment of "D&X" bans, after extensive public debate, by legislatures across the country and by both houses of Congress, has touched off a firestorm of shock and revulsion among the American public at the existence and use of a procedure that has been described as being "literally seconds and inches away from being classified as a murder by every State in the Union." *Partial-Birth Abortion: Hearing Before the Subcommittee on the Constitution of the House Committee on the Judiciary*, 104th Cong. 39 (June 15, 1995) (testimony of Pamela Smith, M.D.). The resultant public exposure of this practice and its similarities to the "D&E" and other procedures, has, in turn, "cast a bright light on the alternative

[abortion] procedures that are equally gruesome . . . [and] could foreseeably cause mothers seeking abortions to have second thoughts, thus giving the potential life in which the state unquestionably has an interest another chance to live." *Planned Parenthood of Wisconsin v. Doyle*, 162 F.3d 463, 476 (7th Cir. 1998) (Manion, J., dissenting).

Thus, for the Court to uphold a law banning the "D&X" procedure based on its function of informing expectant women of what an abortion entails, is fully consonant with the holding of *Casey* that an abortion regulation may legitimately strive to provide women with an informed choice by focusing their attention on the "consequences to the fetus, even where those consequences have no direct relation to her health." 505 U.S. at 882.

II.

A State Law Banning The "D&X" Procedure Advances That State's Significant Interests In Protecting Life By Erecting A Bulwark Against Outright Infanticide And In Expressing The Prevailing Consensus Of Moral Opposition To The "D&X" Procedure

Proscriptions on the use of the "D&X" method may also serve two additional, and related, governmental interests: the creation of a legal and moral bulwark against what a state's legislature may reasonably perceive to be the threat of a creeping social legitimization of infanticide, and the need for that body to give legal expression to the important moral convictions of both the citizenry they represent and society at large.

Recent events in our national life have worked a subtle erosion of the profound, indeed innate, reverence for all human life that has been at the very core of this nation's values since its founding. As this tendency toward the

devaluation of life proceeds, states have an ever more vital interest in making clear, by banning abortion procedures that are nearly indistinguishable from actual infanticide, that the latter practice is irreversibly beyond the pale of civilized society.

Standing in symmetry to the battle over the protection of nascent life is the ongoing controversy, at the other end of life's spectrum, regarding the legality and ethics of assisted suicide. *See, e.g., Washington v. Glucksberg*, 117 S.Ct. 2258 (1997). One state, Oregon, has already given its sanction to this practice, and legal and legislative efforts on its behalf loom in other jurisdictions. One need only read reports of the contemporary Dutch experience with legalized assisted suicide and the ensuing slide into full-fledged euthanasia, to appreciate just how quickly society can traverse the short distance from state-authorized life-ending procedures to the taking of life in a manner that our society presently equates with murder. *See generally* Agudath Israel's *amicus curiae* brief in *Vacco v. Quill* and *Washington v. Glucksberg* (Oct. Term 1996, Nos. 95-1858, 96-110).

Nor are societal attitudes regarding termination of the lives of the elderly and infirm of little relevance to the abortion context. Peter Singer, the influential philosopher of ethics who directs Princeton University's Center for Human Values, argues forcefully in his *Practical Ethics* (2d Ed., Cambridge University Press, 1993) that humans who, although sentient, lack rationality and self-consciousness, should be denied, for moral and legal purposes, the status of personhood. Citing the prevalence of infanticide in ancient Greece as precedent, Singer would legalize the killing of some disabled newborn infants because "infanticide is not necessarily more morally important than abortion, which is morally negligible." (George F. Will, "Life and Death at Princeton," *Newsweek*, Sept. 13, 1999 at 80.)

It is against this backdrop of an increasing desensitization to the sanctity of life at its most defenseless that the interests that a state may seek to promote through its prohibition of the "D&X" procedure must be evaluated. *Casey*'s affirmation of the role abortion regulations may play in furthering the State's "profound interest in potential life" should properly be understood to encompass state laws that have the purpose of stemming and reversing trends that, if left unaddressed, could result in a wholesale slouching toward, and ultimate sanctioning of, outright infanticide.

Beyond the need to employ the "D&X" proscription in defense of yet-to-be-born lives as a roadblock on the path leading down to infanticide, a state may assert yet another clear interest in prohibiting this procedure: to give voice, through its laws, to those ethical principles that are a matter of broad public consensus and thus constitute indispensable elements in the creation of a cohesive social fabric.

That government has a significant interest in expressing and preserving, through its laws, a moral consensus that exists among its citizens has been recognized by justices of the Court in a variety of contexts, ranging from the marriage laws addressed in *Zablocki v. Redhail*, 434 U.S. 374, 399 (1978) (Powell, J., concurring), to the state anti-sodomy statute upheld in *Bowers v. Hardwick*, 478 U.S. 186 (1986) as a legitimate expression of "majority sentiments about the morality of homosexuality." *id.* at 196, to several of the Court's decisions validating state regulation of obscenity as a proper exercise of the state's power to preserve moral standards. *See, e.g., Barnes v. Glen Theatre*, 501 U.S. 560, 569 (1991).

The case now before the Court deals with a method of terminating fetal life that, as noted earlier, has been characterized by physicians and political leaders on both sides of the abortion debate as one that is, in Senator Daniel Patrick

Moynihan's oft-quoted words, "as close to infanticide as anything I have come upon." Nat Hentoff, *Close to Infanticide* (Washington Post, Aug. 30, 1996, at A31). Indeed, from the perspective of classical Jewish law, the procedure most likely would in fact be deemed infanticide. *Mishna, Ahalot* 7:6; see generally J. David Bleich, *Abortion in Halakhic Literature*, reprinted in *Jewish Bioethics* (Hebrew Publishing Co. 1979) at 134. Public opinion polls have consistently registered the opposition of the overwhelming majority of respondents to the use of this procedure. The public's sentiment has, in turn, been enacted into law in thirty state legislatures and, several times, by both houses of Congress, only to be vetoed by the President.

It is difficult to find another matter of public controversy in the moral arena on which there exists a comparable level of national consensus. Surely, then, this is an area in which it is highly appropriate for states to pass laws that embody the moral opprobrium that their citizens, as part of a national majority, have heaped upon a procedure that is unequivocally "gruesome and inhumane." *Evans v. Kelly*, 977 F.Supp 1283, 1319 n.38 (E.D. Mich. 1997).

There may, of course, be those, like the majority in *Doyle*, *supra*, who fail to comprehend "how a rational legislature could sense a moral difference between [methods] of concededly lawful abortion . . . and the partial birth method that the state forbids . . . . " 162 F.3d at 470. Certainly, on as vexed a moral issue as abortion, reasonable persons can be expected to arrive at differing, even antithetical, conclusions.

However, as Judge Manion's dissenting opinion in *Doyle* points out, 162 F.3d at 477, it is in the province of each state's legislators to arrive at their own moral judgment on this issue, speaking on behalf of the citizens who elect them. And it is clear that the Nebraska legislature has made

precisely such a judgment in barring the "D&X" procedure. This judgment should not be disturbed.

CONCLUSION

The Court's ruling in *Casey* was premised in considerable part on "principles of institutional integrity" and the "rule of *stare decisis*". 505 U.S. at 845-46. Those considerations are absent here, where the Court is confronted for the first time with a procedure that approaches, or in fact is, infanticide, and where a broad moral consensus has developed in opposition to the procedure. Agudath Israel respectfully urges that the decision below be reversed.

Respectfully submitted,

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In The

Supreme Court of the United States

DON STENBERG, ATTORNEY GENERAL OF THE STATE OF NEBRASKA, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF AMICI CURIAE of Association of American Physicians and Surgeons, Illinois State Medical Society, Physicians' Ad hoc Coalition for Truth, Christian Medical and Dental Society, Catholic Medical Association, Physicians Resource Council of Focus on the Family, Pennsylvania Physicians Resource Council, Physicians Research Council of the Indiana Family Institute, New Jersey Physicians Resource Council, Oklahoma Physicians Resource Council, Texas Physicians Resource Council, Wisconsin Physicians Resource Council, Drs. Kathi A. Aultman, Gerard Black, Watson A. Bowes, Joseph M. Casey, Byron Calhoun, Steven Calvin, William F. Colliton, Jr., Curtis Cook, Peter R. DeMarco, Fred de Miranda, Eugene F. Diamond, Timothy Fisher, Don Gambrell, Joseph R. McCaslin, Phillip McNeeley, Phillip Metz, Robert Orr, Edmund Pellegrino, Nancy Romer, Pamela Smith, LeRoy Sprang, Dennis D. Weisenburger, and Joseph R. Zanga, IN SUPPORT OF PETITIONERS

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BRIEF AMICI CURIAE IN SUPPORT OF PETITIONERS

This *amici curiae* brief is respectfully submitted on behalf of the Association of American Physicians and Surgeons, Illinois State Medical Society, Physicians' Ad hoc Coalition for Truth, Christian Medical and Dental Society, Catholic Medical Association, Physicians Resource Council of Focus on the Family, Pennsylvania Physicians Resource Council, Physicians Research Council of the Indiana Family Institute, New Jersey Physicians Resource Council, Oklahoma Physicians Resource Council, Texas Physicians Resource Council, Wisconsin Physicians Resource Council, Drs. Gerard Black, Watson Bowes, Joseph M. Casey, Byron Calhoun, Steven Calvin, William F. Colliton, Jr., Curtis Cook, Eugene F. Diamond, Timothy Fisher, Don Gambrell, Phillip McNeeley, Robert Orr, Edmund Pellegrino, Nancy Romer, Pamela Smith, LeRoy Sprang, and Joseph R. Zanga, MD, in support of Petitioners and in favor of reversal of the judgment of the United States Court of Appeals for the Eighth Circuit entered on September 24, 1999.[1]

INTEREST OF THE AMICI CURIAE

Amicus Curiae The Association of American Physicians & Surgeons, Inc. ("AAPS") is a nonprofit organization dedicated to defending the practice of private medicine. Founded in 1943, AAPS has thousands of members nationwide in all specialties. AAPS frequently participates in litigation in defense of the practice of medicine in accordance with the Oath of Hippocrates. Central to

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[1] Pursuant to Rule 37.3 of the Rules of this Court, *Amici* have obtained and file herewith the written consent of each of the parties to the filing of this brief. Counsel for a party did not author this brief in whole or in part. No person or entity, other than the Amici Curiae, its members, or its counsel made monetary contribution to the preparation and submission of this brief.

the interest of AAPS are procedures which, like the one at issue here, are not designed to promote and protect the health of the patient.

Amicus Curiae Illinois State Medical Society ("ISMS") is a nonprofit professional organization with membership of over 16,000 licensed physicians, medical residents and medical students. ISMS policy specifically states:

> ISMS opposes all intact dilation and extraction procedures (Partial-Birth Abortion). (1997 Annual meeting)

ISMS participation is limited to the purposes of this Brief to establish the medical realities surrounding intact dilation and extraction and not the penalties provided in the Nebraska statute.

Amicus Curiae The Physicians' Ad Hoc Coalition for Truth is an organization of more than 600 physicians from around the nation – most specializing in the fields of obstetrics and gynecology, perinatology or pediatrics – that have united to effectively express their opinion that the procedure known as partial-birth abortion is never medically necessary, and often may be contraindicated. This organization takes no position on the ultimate question of whether the current legal protections of abortion should be continued.

Amicus Curiae The Christian Medical & Dental Society (CMDS) was founded in 1941 and today represents over 14,000 members – primarily practicing physicians representing the entire range of medical specialties. This organization views principles of biblical faith as essential to protecting the lives and best interests of patients, the conscientious practice of medicine according to long-standing Hippocratic and religious principles, and to preserving the public respect accorded to physicians as guardians of health and life.

Amicus Curiae Catholic Medical Association ("CMA") is an association of physicians who seek to integrate their understanding of the teachings of the Roman Catholic Church into their professional lives. CMA believes that partial-birth abortion is never medically necessary.

Amicus Curiae Pennsylvania Physicians Resource Council ("PPFC") is an association of physicians concerned for the health and well-being of women and preborn children. PPFC has 250 members and concurs that intact D & X is not recognized as the preferred medical treatment at any stage of pregnancy, nor for any particular condition experienced in pregnancy.

Amicus Curiae Indiana Physicians Research Council ("IPRC") is an association of physicians and part of the Indiana Family Institute. IPRC was instrumental in the passage of a partial birth abortion ban that was enacted by the Indiana General Assembly in 1997.

Amicus Curiae Texas Physicians Resource Council ("TPRC") is a subsidiary of Free Market Foundation of Texas. TPRC represents approximately 500 physicians. TPRC recognizes that the United States Supreme Court's decision in this case will impact medical practice in Texas and endorses the ban on partial birth abortion.

Amicus Curiae New Jersey Physicians Resource Council ("NJPRC") is an association of 45 New Jersey physicians which provides insight on medical, ethical and social issues for policymakers, medical professionals and the public. NJPRC does not believe that partial birth abortion is ever medically indicated to save the life of the mother or to protect her future fertility.

Amicus Curiae Oklahoma Physicians Resource Council ("OPRC") is a multi-specialty organization of Oklahoma physicians. OPRC is associated with Oklahoma Family Policy Council, a nonprofit research and educational organization. OPRC and the physicians associated with it believe that bans against the medical performance of partial-birth abortion procedures are legitimate, moral and ethical public policy positions for states to hold.

Amicus Curiae Physicians Resource Council ("PRC") of Focus on the Family, a California non-profit religious corporation, is an advisory organization that helps identify critical, medically related issues and to form national task forces to develop and implement strategies and objectives to preserve traditional family values. The PRC

is comprised of 22 physicians and oversees the publication of *Physician Magazine* which is received by approximately 74,000 physicians.

Amicus Curiae Wisconsin Physicians Resource Council (WPRC) operates in concert with The Family Research Institute of Wisconsin, Inc. (FRI), which is a charitable and educational organization. The partial-birth abortion issue in this case will impact medical practice in Wisconsin since Wisconsin passed a similar ban in 1998.

Amici curiae Gerard Black, Watson Bowes, Joseph M. Casey, Byron Calhoun, Steven Calvin, William F. Colliton, Jr., Curtis Cook, Eugene F. Diamond, Timothy Fisher, Don Gambrell, Phillip McNeeley, Robert Orr, Edmund Pellegrino, Nancy Romer, Pamela Smith, LeRoy Sprang, and Joseph R. Zanga, are physicians, many of whom have testified before Congress or their state legislatures regarding the medical necessity of the procedure known as "partial-birth abortion."

SUMMARY OF ARGUMENT

Amici offer this brief for the limited purpose of establishing the medical realities surrounding the procedure known as "partial birth abortion," "intact dilation and extraction," or "intact dilation and evacuation." *Amici* believe it is both desirable and constitutional to restrict the use of this procedure as Nebraska has done in this case. On this issue *amici* echo the sentiments expressed by a representative of the American Medical Association ("AMA"):

> This issue is whether the partial delivery of a living fetus for the purpose of killing it outside of the womb ought to be severely restricted. We believe, as a matter of ethical principle, it should rarely *if ever* be done. And although we also believe physicians should have broad discretion in medical matters, both this procedure and

> assisted suicide (as well as female genital mutilation and lobotomies) can and should be regulated if the profession won't do it.

Letter to the New York Times, dated May 30, 1997 by P. John Seward, M.D. in his capacity as AMA Executive Vice President (emphasis added).[2]

As a legitimate health regulation the Nebraska statute succeeds in limiting the use of an unproven and ethically questionable practice, while insuring that safe and effective procedures remain available for women seeking to obtain abortions. While the autonomy of the medical profession is an important and valuable component of the success American medicine has experienced in the attempt to provide the highest quality of care in the world, this interest does not require the profession or the state to disregard practices that erode the public's understanding of and confidence in the physician's role in assisting pregnant women. Dilation and extraction is such a practice, and thus should be prohibited.

ARGUMENT

I. D&X IS GENERALLY RECOGNIZED AS A DISTINCTIVE TECHNIQUE

A. THE FINDINGS OF THE DISTRICT COURT BELOW INDICATE THAT DILATION AND EXTRACTION IS A DISTINCTIVE TECHNIQUE CLEARLY DISTINGUISHABLE FROM DILATION AND EVACUATION AND OTHER ABORTION TECHNIQUES

The legal theories and factual findings by which the district court invalidated Nebraska's Partial-Birth Abortion Prohibitions are in tension with one another. On the one hand, the claim is made that the prohibitions are vague or constitute an undue burden because they

---

[2] Reproduced at App. 7-9 for the convenience of the Court.

encompass not only intact dilation and extraction ("D&X"),[3] but also dilation and evacuation ("D&E") abortion, the latter method being the most common method of second trimester abortion.[4] In accordance with this legal theory, the district court attempted to blur the line between D&X and other methods.[5]

On the other hand, the claim is made that D&X is a distinctive method with health benefits for women beyond that of other methods, including D&E.[6] For this purpose, of course, the district court drew a sharp distinction between D&X and other methods, in order to make comparative claims or findings about the supposed medical superiority of D&X over D&E and other methods.[7]

Obviously, when the district court finds that the D&X procedure is medically superior to other methods, it is implicitly acknowledging that D&X is a distinctive technique, clearly distinguishable from, for example, D&E abortion. Other sections of this brief will take issue with

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[3] This is the term applied to the procedure by its originator when it was first formally discussed among abortion providers. *See* Martin Haskell, *Dilation and Extraction for Late Second Trimester Abortion* (presented at the National Abortion Federation Risk Management Seminar, Sept. 13, 1992), published in *The Partial-Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the Senate Comm. On the Judiciary*, 104th Cong., 1st Sess. 3 (Nov. 17, 1995).

[4] *See, e.g., Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1127-32 (D. Neb. 1998); 192 F.3d 1142, 49-50 (8th Cir. 1999).

[5] *See, e.g., Carhart v. Stenberg*, 972 F. Supp. 507, 525 (D.Neb. 1997) (D&X is a variant of D&E and the difference between the two procedures is not a medical issue, but merely political). 11 F. Supp. 2d at 1106 (claiming that Carhart "intends to remove fetus intact" for all post-fifteen week abortions, although only successful in five to ten percent of such abortions).

[6] *See, e.g., Carhart*, 972 F. Supp. at 525-27; 11 F. Supp. 2d at 1122-23.

[7] *See id.*

the district court findings on the supposed benefits of D&X, and will demonstrate that the statutory definition of "partial-birth abortion" sufficiently distinguishes intact D&X from standard D&E. At the outset, however, it should be recognized that the district court findings themselves presuppose that the D&X procedure is indeed a distinctive method, clearly distinguishable from D&E abortion and other methods.

B. MEDICAL SOURCES INDICATE THAT INTACT D&X IS A DISTINCT TECHNIQUE

The term "D&X" abortion appears to have been introduced by Dr. Martin Haskell in a paper presented at a 1992 National Abortion Federation Conference.[8] The district court below specifically described the "Haskell D&X" as follows:

> On the first and second days of the procedure, Dr. Haskell inserts dilators into the patient's cervix. On the third day, the dilators are removed and the patient's membranes are ruptured. Then, with the guidance of ultra-sound, Haskell inserts forceps into the uterus, grasps a lower extremity, and pulls it into the vagina. With his fingers, Haskell then delivers the other lower extremity, the torso, shoulders, and the upper extremities. The skull, which is too big to be delivered, lodges in the internal cervical os. Haskell uses his fingers to push the anterior cervical lip out of the way, then presses a pair of scissors against the base of the fetal skull. He then forces the scissors into the base of the skull, spreads them to enlarge the opening, removes the scissors, inserts a suction catheter, and evacuates the skull contents. With the head decompressed, he then removes the fetus completely from the patient.

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[8] *See* Haskell, *supra*.

972 F. Supp. at 516 (quoting *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051 (S.D. Ohio 1995)).

Dr. Haskell's 1992 paper explains the distinction between D&X and other methods as follows:

> The surgical method described in this paper differs from classic D&E in that it does not rely upon dismemberment to remove the fetus. Nor are inductions or infusions used to expel the intact fetus.
>
> Rather, the surgeon grasps and removes a nearly intact fetus through an adequately dilated cervix. The author has coined the term *Dilation and Extraction* or *D&X* to distinguish it from dismemberment-type D&E's.
>
> . . . .
>
> Classic D&E is accomplished by dismembering the fetus inside the uterus with instruments and removing the pieces through an adequately dilated cervix.[9]

As the district court found, Dr. Haskell employed his new method for pregnancies that had progressed to twenty weeks or beyond.[10] Dr. Haskell's 1992 paper explained that classic D&E dismemberment became difficult beginning at twenty weeks due to "the toughness of fetal tissues at this stage of development." Alternative D&E methods involved causing fetal death by various methods prior to surgery, to produce softening of fetal tissues. Late second trimester abortions could also be performed by induction methods. Dr. Haskell's D&X method was a new procedure that resolved the problem of fetal tissue toughness post-twenty weeks by providing a non-induction, non-dismemberment technique.[11] Instead of either dismembering the fetus piece by piece

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[9] *See* Haskell, *supra*.

[10] 972 F. Supp. at 516.

[11] *See id.*

through the cervix or inducing labor, Dr. Haskell provided extensive dilation in a three-day procedure, then delivered all but the head of the fetus into the vagina, followed by reduction of the head size through evacuation of the skull contents, allowing complete delivery of the fetus.

There has been a certain amount of confusion over the correct term for this distinctive procedure. At the time that Dr. Haskell presented his paper there were no references to this procedure in any medical textbooks, dictionaries, or journals. Even standard texts on abortion, such as Warren Hern, *Abortion Practice* (1990 reprint), did not name or describe the procedure. Dr. Haskell claimed to have "coined the term Dilation and Extraction or D&X".[12] However, another physician employing the method, Dr. James T. McMahon, chose the slightly different name "intact dilation and evacuation (intact D&E)."[13] Subsequently, abortion rights proponents such as the National Abortion Federation and Planned Parenthood divided over the right terminology, the former adopting Haskell's terminology,[14] the latter McMahon's.[15] Both organizations claimed their term the proper "medical" one, in supposed contrast to the term "partial-birth abortion," which was derided by advocates of the procedure as a non-medical term.[16] In the absence of any published descriptions of

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[12] Haskell, *supra*.

[13] *See* James Bopp & Curtis R. Cook, *Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence*, 14 Issues L. & Med. 3, 20 (1998).

[14] Planned Parenthood Federation of America, *Fact Sheet: Why Abortion Bans are Unconstitutional* (visited February 22, 2000) <http://www.plannedparenthood.org/library/ABORTION/abortban__fact.html.>

[15] National Abortion Federation, *NAF's Response to "Partial-Birth Abortion" Ban* (visited February 22, 2000) <http://www.prochoice.org/issues/ban.htm.>

[16] *See id.*

the term in medical textbooks, dictionaries, or standard medical journals, and amidst political controversy over proposed bans on partial-birth abortion which were aimed at prohibiting the new Haskell/McMahon procedure, it was difficult to standardize precise medical terminology for the new procedure.

Subsequently the American College of Obstetricians and Gynecologists ("ACOG") issued a January 1997 statement adopting a hybrid term "intact dilation and extraction" or "intact D&X," combining the Haskell/McMahon definitions. The American Medical Association relied upon this report in issuing its own policy declarations. Therefore, the term "intact dilation and extraction" or "intact D&X" – which is sometimes shortened simply to "D&X" – appears to have become the most common appellations for the procedure in question.[17]

ACOG states that intact D&X has been described as including the following four elements:

> (1) the deliberate dilation of the cervix, usually over a sequence of days;
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> (2) instrumental conversion of the fetus to a footling breech;
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> (3) breech extraction of the body, excepting the head; and
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> (4) partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

11 F. Supp. 2d at 1105.

The ACOG acceptance of this description indicates once again that D&X is medically understood as a distinctive technique, different from classic D&E abortion, even if it is sometimes denominated as a variant form of D&E. This four-part description is useful so long as it is not

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[17] *See* 11 F. Supp. 2d at 1105 & n.10. Amici do not suggest that unanimity has emerged on the proper name of this procedure, even at this time.

taken too literally. For example, dilation is "usually over a sequence of days" post twenty weeks, but prior to twenty weeks instrumental dilation not requiring this extended time frame may be employed.[18] (This is significant to the present case, as the Respondent Dr. Carhart testified that he only performed D&X from 16 to 20 weeks.)[19] Secondly, as Dr. Frank Boehm, professor of obstetrics and gynecology at the Vanderbilt University School of Medicine and Director of Obstetrics for the hospital, noted in testimony before the district court, version (or purposeful manipulation) is only needed when the fetus does not present in breech.[20] In the present case Dr. Carhart testified that he only chose to perform a D &X when the fetus presented in breech or where repositioning the fetus from a side presentation resulted in a breech presentation.[21]

The medical literature on D&X, although severely limited, takes into account these slight variations in technique. For example, in an article based on the AMA Board of Trustees 1997 Report, which was approved by the AMA House of Delegates in June 1997, the authors quote the ACOG description of intact D&X, then note "However, there may be variations of D&X that depart from this protocol, such as when an identical procedure is

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[18] "For procedures at up to 16 weeks' gestation, placing the dilators 4-8 hours prior to surgery may suffice. Beyond 16 weeks it is common practice to allow overnight dilation, and some mid to late second trimester protocols call for a second insertion in 16-24 hours." W. Martin Haskell *et al.*, *Surgical Abortion After the First Trimester* in *A Clinician's Guide to Medical and Surgical Abortion* (Maureen Paul, *et al.*, 1999) at 128.

[19] 972 F. Supp. 507 at 514-15.

[20] Ex. 32, Videotaped Dep. of Dr. Boehm at 31:23-32:6. This point was first noted by Dr. Haskell in his 1992 paper presented at the National Abortion Federation Fall Risk Management Seminar. See Haskell, *Dilation and Extraction*, *supra* ("Version (as needed)").

[21] 972 F. Supp. at 522 n.20.

performed without converting the fetus to a footling breech or using decompression without suction evacuation of the cranial contents."[22]

The Nebraska statute takes account of these variations, and other variations which at this point are not seriously proposed by any medical professional (e.g., intentionally delivering a live fetus head-first in order to kill it before completed delivery). A more detailed medical definition could invite practitioners to evade the law by modifying other minor details of the procedure. What remains the same throughout these variations and distinguishes the D&X procedure from other abortion techniques is: (1) Deliberate dilation of the cervix, technique and duration variable depending on stage of pregnancy and other factors; (2) Instrumental or manual conversion of the fetus to a footling breech where necessary; (3) Breech extraction of the body except the head; and (4) Reduction of the head size of a living fetus through methods such as decompression or evacuation of the intracranial contents to effect vaginal delivery of a dead, but otherwise intact, fetus.

II. INTACT D&X IS NOT RECOGNIZED WITHIN THE MEDICAL PROFESSION AS THE PRIMARY INDICATED TECHNIQUE OR STANDARD OF CARE AT ANY STAGE OF PREGNANCY OR FOR ANY PREGNANCY, AND THEREFORE CANNOT BE CONSIDERED MEDICALLY SUPERIOR TO THE STANDARD METHODS OF SECOND TRIMESTER ABORTION, SUCH AS D&E.

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[22] Janet E. Gans Epner, *et al.*, *Late-Term Abortion*, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26, 1998). See also W. Martin Haskell, *et al.*, *Surgical Abortion After the First Trimester* 136-7 in *A Clinician's Guide to Medical and Surgical Abortion* (Maureen Paul, *et al.* eds., 1999) (discussing variations in procedure for breech and vertex position).

A. THE DISTRICT COURT ISSUED CONTRADICTORY FINDINGS OF FACT REGARDING THE SUPPOSED SUPERIORITY OF INTACT D&X WHICH MUST BE REGARDED AS CLEARLY ERRONEOUS

The district court correctly found, and the court of appeals agreed, that standard D&E abortion is the most common abortion method during the relevant gestational period.[23] This finding is supported by the practice of Respondent Dr. Carhart, who was found to perform standard D&E abortion rather than intact D&X in approximately ninety percent of his post-fifteen week abortions.[24] Although Dr. Haskell designed the D&X originally for the post-twenty-week period, the district court found that Respondent Dr. Carhart chose *not* to perform a D&X post-twenty weeks, but instead "induces fetal death by injection."[25] During the period from sixteen to twenty weeks Dr. Carhart only performs the D&X procedure when he finds the fetus in breech (or sometimes transverse, or side) presentation. Thus he employs D&X in approximately ten to twenty abortions out of the 190 sixteen-to-twenty-week abortions he performs annually.[26] The district court also recorded Dr. Carhart's procedure if he found the fetus presenting in transverse (sideways) position:

> Carhart grasps whatever portion of the fetus he can in order to turn it so that part of the body will pass through the cervix. He performs this procedure because "you can't bring the fetus out sideways." If he can grasp the fetus "feet first"

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[23] 11 F. Supp. 2d at 1127-30; 192 F.2d at 1149-51 (D&E most common abortion method for second trimester abortions).

[24] *See* 972 F. Supp. at 520-22.

[25] See 972 F. Supp. at 522.

[26] 972 F. Supp. at 511, 520, 521 & n.20.

> he will, but Carhart does not "intentionally spend a lot of time doing that."

972 F. Supp. at 521 n.20 (quoting portions of Dr. Carhart's testimony).

Finally, the district court found that Dr. Carhart was, so far as he knew, the only provider of post-sixteen-week abortions in Nebraska, and therefore the only physician in the state who performed the D&X procedure.[27]

The district court in summary found: (1) Standard D&E abortion is the most common method used during the relevant gestational period; (2) Respondent, the only provider of abortions during the relevant gestational period, chooses D&E over D&X approximately ninety percent of the time; and (3) Respondent allowed the presentation of the fetus during the period from sixteen to twenty weeks to determine which method he employed, and cared so little which technique he used that, when faced with a transverse lie, he did not "intentionally" spend "a lot of time" seeking to grasp the feet so that he could perform a D&X rather than D&E.

Directly contradictory to these findings, the district court also found that "medical evidence established that the D&X procedure is appreciably safer for women than the D&E procedure."[28] The district court relied on claims that D&X was superior to D&E because of (1) less chance of trauma to the cervix and uterus from bony fragments; (2) less instrumentation in the uterus, lessening the risk of complications from tearing or perforating the uterus; (3) prevention of disseminated intravascular coagulopathy and amniotic fluid embolus; (4) reduced chance of retained fetal parts; (5) reduced risk of free floating head; and (6) shorter operating time, reducing the amount of bleeding and the risks of hemorrhage and infection.[29] The only evidence offered to support the existence of these

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[27] 972 F. Supp. at 511.

[28] 972 F. Supp. at 525.

[29] *See id.* at 526-27.

benefits was the testimony of the Respondent and the speculation of experts. The record is void of any controlled study or article from a peer-reviewed journal establishing that the D&X procedure is superior in any way to the D&E procedure most commonly employed in second and third trimester abortions.[30]

All the reasons given by the district court for finding intact D&X "appreciably safer for women" than D&E, if valid, would apply to the ninety percent of abortions for which Respondent Carhart chose *not* to perform a D&X. Moreover, the district court opinions fail to list any potential negative effects of the D&X procedure. Therefore, the findings of the district court suggest that Respondent Carhart, and indeed the vast majority of

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[30] The only generally available medical publication to make similar claims on behalf of the procedure is a recently published medical text, *A Clinician's Guide to Medical and Surgical Abortion* (Maureen Paul, *et al.* eds.) (1999). Based exclusively upon the self-reporting of the deceased Dr. James T. McMahon, one of the originators of the D&X procedure, the text states "This major complication rate is virtually identical to that of an earlier series of nonintact D&E's reported by Hern (3.07 [per] 1000 cases) despite the fact that nearly one-fourth of the cases in McMahon's series exceeded Hern's 25-week gestational limit." W. Martin Haskell, *et al.*, *Surgical Abortion After the First Trimester*, in *A Clinician's Guide to Medical and Surgical Abortion*, *supra* at 137. This information was available at the time of trial, yet in the absence of any external review or indicia of reliability, none of the Respondent's experts or the district judge considered it relevant. Even taken at face value this statement provides little support for the finding of the district court that D&X is superior to D&E.

The chapter goes on to assert "Haskell [the other originator of D&X and co-author of the chapter] has performed more than 1500 intact D&E's at 20-26 weeks' gestation without a serious event." *Id.* No information is provided regarding the methodology of follow-up to obtain information about delayed complications, nor is there an adequate explanation of Haskell's or McMahon's definition of what constitutes a complication.

second-trimester abortion providers, are guilty of deliberately failing to choose an "appreciably safer" method of abortion, D&X.

The district court findings are self-contradictory. They simultaneously condemn the State of Nebraska for allegedly making illegal the most common form of second trimester abortion (D&E), while also claiming that this same method is, as measured against D&X, so medically deficient as to constitute a serious health risk for women.

The district court findings on the safety of D&X, in short, cannot be taken seriously as "findings of fact," but instead should be read merely as alternative legal theories. Alternative legal theories or alternative rationales, even where offered by a district court, cannot however, be accorded the same weight as findings of fact. Surely a single district judge lacks the authority to condemn as medically deficient and unsafe a procedure – D&E abortion – which is clearly within the current standard of care for second trimester abortion.[31]

Ironically, the district court condemned as "irrelevant" "political rhetoric" prior statements issued by the AMA supporting the proposed Partial-Birth Abortion Ban Act of 1997, H.R. 1122.[32] To disregard the predominant practice of substantially all physicians, including the Respondent, and condemn the statements of the largest organized group of physicians in the country as merely "political" fuels the public perception in some quarters that abortion jurisprudence is driven by the personal or political preferences of the judiciary, rather than reasoned

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[31] Paul D. Blumenthal, *et al.*, *Abortion by Labor Induction*, in *A Clinician's Guide to Medical and Surgical Abortion*, *supra* at 139 ("Compared to induction abortion, dilation and evacuation (D&E) has generally been recognized as the safest and most expeditious means of pregnancy termination for similar gestational ages, specially prior to 20 weeks").

[32] 972 F. Supp. at 525 n.27.

interpretation of medical facts and constitutional limitations. In light of the common practice of all physicians testifying in this case, and the statements of the larger medical community that no circumstances necessitate the use of intact D&X, the findings of the district court on the supposed medical superiority of intact D&X abortion must be set aside as clearly erroneous.

B. MEDICAL SOURCES INDICATE THAT INTACT D&X IS NOT THE STANDARD OF CARE OR PREFERRED METHOD AT ANY STAGE OF PREGNANCY OR FOR ANY PREGNANCY, AND MAY HAVE SIGNIFICANT MATERNAL HEALTH RISKS THAT WERE NOT CONSIDERED BY THE DISTRICT COURT

The varied statements by ACOG and the AMA reflect professional organizations caught between two impulses. On the one hand, it is clear, as reflected for example by *amici*, that there are significant numbers of physicians and health care providers who hold that intact D&X is both medically and ethically objectionable.[33] Further, D&X is not the standard of care or preferred

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[33] " 'I have very serious reservations about this procedure,' " said Colorado physician Warren Hern, M.D. The author of *Abortion Practice*, the nation's most widely used textbook on abortion standards and procedures, Dr. Hern specializes in late-term procedures . . . of the procedure in question he says, " 'You really can't defend it.' " Diane M. Gainelli, *Outlawing abortion method: Veto-proof majority in House votes to prohibit late-term procedure*," 38 Amer. Med. News 1 (Nov. 20, 1995) (reproduced at App. 11-20 for the convenience of the Court); M. LeRoy Sprang & Mark G. Neerhof, *Rationale for Banning Abortions Late in Pregnancy*, 280 J. Amer. Med. Ass'n 744 (Aug. 26, 1998); and Janet E. Gans Epner, *et al.*, *Late-term Abortion*, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26, 1998) ("[i]n the absence of controlled studies, the relative advantages and disadvantages of the procedure in specific circumstances remain unknown").

method at any stage of pregnancy or for any pregnancy, according to current medical literature and standards. On the other hand, professional organizations such as ACOG and the AMA have an understandable tendency to resist governmental regulation of medical procedures and medical providers, particularly when regulation may involve criminal sanctions.

These conflicting impulses are well illustrated by the ACOG and AMA literature pertaining to intact D&X/ partial-birth abortion. A January 1997 ACOG statement, after describing the intact D&X procedure, stated:

> A select panel convened by the ACOG could identify no circumstances under which this procedure [intact D&X] . . . would be the only option to save the life or preserve the health of the woman. An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision.

See 11 F. Supp. 2d at 1105 n.10.

The first sentence of the ACOG statement reflects the failure of medical experts to identify any stage of pregnancy or particular circumstance in which intact D&X abortion represents the standard of care, or would be medically necessary to protect the life or health of women. In direct opposition to the clearly erroneous finding of the district court that intact D&X was generally and appreciably safer than the predominant D&E, the ACOG's panel of experts could not identify a *single circumstance* where D&X is medically superior. A subsequent policy statement by the AMA agreed, finding that "there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion." AMA Policy H-5.982, *quoted in Hope Clinic v. Ryan*, 195 F.3d 857, 872 (7th Cir. 1999) (en banc).

These expert findings of ACOG and the AMA were employed by the AMA when it issued statements in support of the Partial-Birth Abortion Ban of 1997, which is quite similar to the Nebraska law at issue herein. The AMA Board of Trustees Press Release and Fact Sheet took the position that the federal bill did *not* prohibit D&E, but only prohibited intact D&X. The AMA press release described that procedure as "broadly disfavored – both by experts and the public. . . . It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development."[34] The AMA Board of Trustees Fact Sheet on HR 1122 stated that "Intact D&X is not an accepted 'medical practice'. . . . the Board's expert scientific report recommends against its use."[35]

While ACOG has consistently opposed legal prohibition of intact D&X/partial birth abortion, and the AMA has taken varying positions regarding such legislation, neither organization has yet offered any specific circumstances in which the procedure is believed to be medically necessary. ACOG's statement that there "may" be such circumstances is clearly just another way of expressing generalized opposition to legislative regulation of physicians. Indeed, when interviewed by American Medical News about this statement, ACOG President Fredric D. Frigoletto, Jr., "maintained that the [ACOG Executive] Board did not 'endorse' the procedure. 'There are no data to say that one of the procedures is safer than the other,' he said. When asked why the statement said the procedure 'may be the best' in some cases, Dr. Frigoletto

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[34] American Medical Association, *AMA Press Releases: AMA Supports H.R. 1122 As Amended, Statement by Nancy W. Dickey, MD, Chair of the AMA Board of Trustees* (reproduced at App. 5-6 for the convenience of the Court).

[35] American Medical Association, *AMA Board of Trustees FACT SHEET on HR 1112* (June 1997) (reproduced at App. 1-4 for the convenience of the Court).

answered, 'or it may not be.' "[36] Such reference to the bare possibility of health risks by a professional organization opposed in principle to legislative regulation of abortion cannot constitute an "undue burden," if the undue burden test is to play its role of distinguishing between permissible and impermissible governmental regulation.

The district court below acknowledged as correct the statement of its most favored expert, Dr. Stubblefield,[37] that there are no medical studies "which compare the safety of the intact D&X to other abortion procedures or conclude that the D&X is safer than other abortion procedures."[38] Two published articles in The Journal of the American Medical Association relating to the D&X procedure have also noted the lack of credible studies on safety.[39]

The district court, not fearing to tread beyond the confines of published studies and the expert panels of ACOG and the AMA, dismissed the lack of published studies as unimportant.[40] The district court relied largely upon Dr. Stubblefield, "a teacher and user of the D&E

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[36] Diane M. Gianelli, *Medicine adds to debate on late-term abortions: ACOG draws fire for saying procedure 'may' be best option for some*, 40 Amer. Med. News 1 (March 3, 1997) (reproduced at App. 21-27 for the convenience of the Court).

[37] *See* 11 F. Supp. 2d at 1116 (Dr. Stubblefield most persuasive and helpful expert).

[38] 11 F. Supp. 2d at 1112.

[39] *See* Janet E. Gans Epner, *et al., Late-term Abortion*, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26 1998) ("[i]n the absence of controlled studies, the relative advantages and disadvantages of the procedure in specific circumstances remain unknown"); M. LeRoy Sprang & Mark G. Neerhof, *Rationale for Banning Abortions Late in Pregnancy*, 280 J. Amer. Med. Ass'n 744 (Aug. 26, 1998) ("no credible studies on intact D&X that evaluate or attest to its safety").

[40] *See, e.g.*, 11 F. Supp. 2d at 1124.

procedure,"[41] to buttress claims that the D&X procedure was medically superior to D&E abortion, despite the fact that Dr. Stubblefield "has not performed this procedure himself, nor has he viewed anyone else perform it."[42] The court never appears to have wondered why Dr. Stubblefield, its favored expert, had never used or taught the intact D&X procedure if he believed it to be superior to D&E. Nor was the district court deterred by Dr. Stubblefield's testimony that characterized the possible health benefits of D&X as mere theory which should be regarded as uncertain pending data.[43] Similarly, Respondent's other expert, Dr. Hodgson, who had "performed or supervised at least 30,000 abortions,"[44] and yet had never intentionally performed an intact D&X,[45] was relied upon to buttress claims of D&X as a "technological advance."[46] Such appearance of a "courtroom conversion" by Respondent's experts, who adhere to the D&E in their medical practice while opining about the supposed superiority of the D&X inside the courtroom, undermines any support for the findings of the district court.

The district court's speculations on why D&X is superior to D&E failed to mention or take account of the special risks that may be associated with D&X. First, "some physicians have suggested that the procedure may increase complications, such as cervical incompetence."[47] The threat of cervical incompetence is related to the

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[41] 11 F. Supp. 2d at 1125 n.35.

[42] 11 F. Supp. 2d at 1112.

[43] *See* 11 F. Supp. 2d at 1111 ("theoretically, would be safer. It would be a while before we have the data to compare. . . . ")

[44] 11 F. Supp. 2d at 1105.

[45] *See* 11 F.2d at 1105, 972 F. Supp. at 516.

[46] *See* 972 F. Supp. at 516.

[47] 280 J. Amer. Med. Ass'n at 726 (footnote omitted).

amount of cervical dilation.[48] Cervical incompetence consequent to intact D&X may make it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term.

Further risks peculiar to intact D&X are described as follows:

> First, the risk of uterine rupture may be increased. An integral part of the D&X procedure is an internal podalic version, during which the physician instrumentally reaches into the uterus, grasps the fetus' feet, and pulls the feet down into the cervix, thus converting the lie to a footling breech. The internal version carries risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus. According to *Williams Obstetrics*, "there are very few, if any, indications for internal podalic version other than for delivery of a second twin."[49]

The risk of podalic version (repositioning the fetus) referred to in *Williams Obstetrics* involves manual internal version (repositioning by hand within the woman's body) to deliver a fetus in the third trimester. While this differs somewhat from version (repositioning) of the fetus with an instrument as described by Haskell in the D&X procedure, the risks of Haskell's procedure are unknown, and can only be the subject of speculation based upon the risks of similar, but not identical procedures.

> The second potential complication of intact D&X is the risk of iatrogenic laceration and secondary hemorrhage. Following internal version and partial breech extraction, scissors are forced into the base of the fetal skull while it is lodged in the birth canal. This blind procedure risks maternal injury from laceration of the uterus or

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[48] A. Golan, *et al.*, *Incompetence of the Uterine Cervix*, 44 Obstet. Gynecol. Surv. 96-107 (1989).

[49] 280 J. Amer. Med. Ass'n at 744-45 (footnote omitted).

> cervix by the scissors and could result in severe bleeding and the threat of shock or even maternal death.[50]

All of these risks, if realized, have significant import for maternal health.

The district court's failure to take account of the negative risks associated with D&X in its supposed findings on the comparative superiority of intact D&X, alone renders those findings clearly erroneous. Any comparative analysis of the various techniques applicable to a specific stage of pregnancy or circumstance must obviously take account of the relative risks of *both* procedures to be valid. Simply listing the risks associated with second trimester D&E abortion, as the court did,[51] fails utterly to constitute findings of fact on the *comparative* risks of D&E and D&X.

Amici believe that the nearly eight years that have passed since Dr. Haskell's 1992 paper on intact D&X have demonstrated that the procedure is never medically necessary, and remains generally inferior, in terms of maternal health, to existing abortion methods. Although abortion rights orientated experts are clearly willing to go into federal court and testify as to the efficacy of the D&X, physicians have retained their preference, in actual practice, for various forms of D&E and induction methods.[52] Professional organizations with strong interests in professional autonomy and maternal health have been unable to identify any particular circumstances where there is a need for the procedure. While the AMA

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[50] *Id.* (footnotes omitted).

[51] *See* 11 F. Supp. 2d at 1123.

[52] *See, e.g.*, David A. Grimes, *The Continuing Need for Late Abortions*, 280 J. Amer. Med. Ass'n 747, 748 (Aug. 26, 1998) ("only a small number of physicians nationwide" perform intact dilation and extraction).

no longer supports the federal ban on partial-birth abortion due to its overall opposition to criminal sanctions against physicians, the AMA continues to oppose this procedure.[53] Rather than being a new method on the rise, D&X remains after almost eight years an aberrant curiosity, a medically needless flashpoint of deeply-felt division.

The weakness of the record in the instant case contrasts strangely with the supposed findings of the district court. None of the experts in the instant case had ever performed a D&X procedure. Even Respondent Carhart performed the D&X procedure in only about ten percent of his post-fifteen week abortions. Moreover, Carhart did not identify particular circumstances that necessitated use of D&X, but instead chose the procedure based on the happenstance of the presentation of the fetus, failing even in transverse presentations to make sustained efforts to effect a D&X procedure. The actions of the Respondent and his experts undercut any claims or finding of medical necessity for this procedure.

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[53] An October 21, 1999 "Statement For Response Only" issued by the AMA states:

> U.S. Senator . . . Santorum . . . has reintroduced a bill that would ban intact dilation and extraction. The American Medical Association (AMA) has previously stated our opposition to this procedure. We have not changed our position regarding the use of this procedure.
>
> The AMA has asked Sen. Santorum to remove the criminal sanctions from his bill, but such a change has not been made. For this reason we do not support the bill.

American Medical Association, *Statement for Response Only* (Oct. 21, 1999) (reproduced at App. 10 for the convenience of the Court).

C. THERE ARE NO SPECIAL MEDICAL OR HEALTH INDICATIONS FOR D&X

The district court's over-reaching, clearly erroneous "finding" that the D&X procedure is generally superior to the more common and generally accepted methods, in combination with the fact that Respondent Carhart chose D&X based on the happenstance of fetal position, rather than special maternal indications, makes this case a particularly poor candidate for exploring whether there may be rare cases where D&X is necessary to maternal health. Neither the district court nor the appellate court below relied to a significant degree on such a claimed need for D&X in specialized or extreme medical circumstances. Nonetheless, *amici*, having extensive experience with a wide variety of difficult medical circumstances related to maternal-fetal health, wish to emphasize that speculations on a supposed need for the D&X procedure in particular circumstances are groundless. This fact is not changed by the invocation of the emotionally charged circumstances surrounding tragic fetal abnormalities.

1. INTACT D&X ABORTION IS NOT INDICATED FOR HYDROCEPHALUS

Hydrocephalus, or excessive fluid accumulated in the fetal head, has sometimes been offered as a condition necessitating intact D&X, due to the impossibility of normally delivering the enlarged head. Of course, as ACOG and the AMA have noted, D&X has never been identified as the standard of care or indicated treatment for any particular circumstances. In fact, the usual treatment for hydrocephalus is transabdominal cephalocentesis, whereby the excess fluid in the fetal skull is drained through the use of a thin needle placed inside the womb through the woman's abdomen.[54] By contrast, proceeding transvaginally with scissors – the very crude method

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[54] *See, e.g.*, 280 J. Amer. Med. Ass'n at 745.

adopted by Haskell – or even a needle places the woman at an increased risk of infection because of the non-sterile vaginal environment.

2. INTACT D&X IS NOT INDICATED OR NECESSARY IN ORDER TO DIAGNOSE FETAL ABNORMALITIES

It has sometimes been stated that it is useful to have an intact fetus in order to confirm abnormal prenatal diagnoses.[55] However, "a study involving 60 patients who underwent D&E at 14 to 22 weeks of gestation after fetal abnormalities were detected found that D&E successfully and consistently confirmed abnormal prenatal diagnoses."[56] Notwithstanding the results of these studies, to the extent that intact fetal salvage is desirable, this can be achieved through labor induction abortion.[57] Again, intact D&X upon examination has failed to become the standard of care *for any particular circumstance*, as there are always medically-sound alternatives.

III. INTACT D&X CONFUSES THE DISPARATE ROLES OF A PHYSICIAN IN CHILDBIRTH AND ABORTION IN A WAY THAT BLURS THE LINE BETWEEN INFANTICIDE AND ABORTION AND

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[55] *See* W. Martin Haskell, *et al., Surgical Abortion After the First Trimester* in *A Clinician's Guide to Medical and Surgical Abortion* (Maureen Paul, *et al.* eds., 1999) at 136.

[56] 280 J. Amer. Med. Ass'n at 727 (footnote number omitted) (citing L.P. Shulman, *et al., Dilation and evacuation for second-trimester genetic pregnancy termination*, 75 Obstet. Gynecol. 1037-40 (1990); *see also* W. Hern, *et al., Outpatient abortion for fetal anomaly and fetal death from 15-34 menstrual weeks' gestation: Techniques and clinical management* 81 Obstet Gynecol 301-06 (1993)).

[57] W. Martin Haskell, *et al., Surgical Abortion After the First Trimester in A Clinician's Guide to Medical and Surgical Abortion* (Maureen Paul, *et al.* eds., 1999) at 125.

UNDERMINES THE PUBLIC INTEGRITY OF THE MEDICAL PROFESSION

Even abortion rights proponents have frequently expressed a particularly negative reaction to intact D&X, otherwise known as partial-birth abortion. This negative reaction is frequently shared by medical providers who are well acquainted with the relative gruesomeness of surgery and particular methods of abortion. There is something particularly shocking and aberrant about this particular procedure beyond, or different from, the difficult issues raised by abortion itself.

Intact D&X is aberrant and troubling because the technique confuses the disparate roles of a physician in childbirth and abortion in such a way as to blur the medical, legal, and ethical line between infanticide and abortion. When the physician performs (as necessary) instrumental version of the live fetus to a footling breech – using terminology (footling breech) and techniques borrowed from past and current obstetrics – she appears initially to be assisting live delivery. As the physician manually performs breech extraction of the body of a live fetus, excepting the head, she continues in the apparent role of an obstetrician delivering a child. At this point of the procedure it is possible for all of the fetus' body, except for the head, to be outside of the woman's body, and the physician is holding the fetus' live body in one of her hands. The techniques used to this point of the procedure appear to be clear adaptations of the role of a physician acting with a duty of care to both fetus and woman, and the fetus is remarkably close – whether viable or not – to achieving live delivery.

Suddenly, the physician appears to switch roles and performs an act quite contrary to the obstetrical role: stabbing the base of the skull of the living fetus with a pair of scissors, spreading the scissors to enlarge the opening, inserting a suction catheter, and evacuating the skull contents. The physician acts directly against the physical life of a fetus who she has previously delivered, all but the head, out of the uterus. Even when the method

is altered somewhat to involve other means of "evacuating" or "decompressing" the fetal skull, this portion of the intact D&X dramatically shifts the technique and role of the physician from delivery of a live fetus out of the womb to destroyer of a fetus almost entirely outside the uterus.

Even abortion rights proponents recognize that post-fifteen-week abortions are difficult and troubling for all involved.[58] However, the reason that Congress and thirty state legislatures have, usually by wide margins, passed bans on intact D&X abortion amounts to more than a negative response to second and third trimester abortion, and more than discomfort with the raw gruesomeness of surgery or late-term abortion. Rather, in a society that, due to this Court's precedents, must permit elective pre-viability abortion and health-indicated post-viability abortion, there is a medical, legal, and ethical imperative to draw a bright, unblurred line between infanticide and abortion. Intact D&X threatens this bright line between infanticide and abortion in a way that undermines both the public integrity of the medical profession and society's interest in protecting human life.

IV. NEBRASKA'S USE OF THE TERM "PARTIAL-BIRTH ABORTION" AND ACCOMPANYING DEFINITIONS FAIRLY DISTINGUISH INTACT D&X FROM STANDARD D&E ABORTION WHILE EXPRESSING THE STATE INTEREST IN DRAWING A BRIGHT LINE BETWEEN INFANTICIDE AND ABORTION

Even today, there is no fixed medical term for the procedure at issue herein. While ACOG and the AMA appear generally to use the term "intact dilation and extraction," as late as August 1998 the well-known

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[58] David A. Grimes and Willard Cates, Jr., *"Dilation & Evacuation"* in *Second Trimester Abortion: Perspectives After a Decade of Experience* (Gary S. Berger, *et al.* eds., 1981) at p. 130.

reproductive health expert David A. Grimes used the term "intact D&E."[59] The district court below seemed somewhat challenged by the medical terminology, referring to the procedure alternatively as "intact dilation and evacuation," "intact D&X," "intact D&E," and "intact dilation and extraction."[60] Yet it also used one of these terms (intact D&E) for a different procedure in which the fetus is entirely within the uterus – and in one instance already dead – when the fetal skull size is reduced.[61] Moreover, despite claims that the term "intact dilation and extraction" is a medical term, the district court referred to this term as emanating from "the popular press."[62]

Under these circumstances, the Nebraska legislature, acting in 1997, cannot be fairly criticized for failing to use a medical term, as medical terminology has been evolving and uncertain. Moreover, the medical terminology fails to express the state's interests in drawing a clear line between infanticide and abortion which safeguards the public integrity of the medical profession. The term "partial-birth abortion" expresses reasonably well the gravamen of the objection to this procedure, which is that the procedure confuses the role of physician in childbirth and physician in abortion, blurs the line between infanticide and abortion, and undermines the public integrity of the medical profession. "The 'partial birth abortion' legislation is by its very name aimed exclusively at the procedure by which a 'living fetus' is 'intentionally and

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[59] David A. Grimes, *The Continuing Need for Late Abortions*, 280 J. Amer. Med. Ass'n 747, 748 (Aug. 26, 1998).

[60] *See, e.g.*, 11 F. Supp. 2d at 1105.

[61] *See* 11 F. Supp. 2d at 1111-12.

[62] 11 F. Supp. 2d at 1105.

deliberately' given 'partial birth' and 'delivered' for 'for the purpose of' killing it."[63]

In their statutory construction the courts below have failed to interpret the statute in accord with its clearly expressed purpose. It is perverse to focus exclusively on the term "substantial portion," apart from the purposes of the act and important statutory terms such as "partial-birth abortion," "delivers," "delivers vaginally a living unborn child before killing the unborn child." Properly interpreting the various terms of the statute in light of the statute's purpose, the definition of partial-birth abortion clearly excludes the dismemberment of the fetus as is common with D&E abortion. There is certainly nothing resembling a "partial birth" in classic Dilation and Evacuation (D&E) abortion, nor does a D&E resemble intentional "delivery" of a living fetus into the birth canal.

CONCLUSION

For the foregoing reasons, we respectfully request that this Court reverse the judgments of the district court and Court of Appeals.

Respectfully submitted,

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[63] American Medical Association, *AMA Board of Trustees FACT SHEET on HR 1122* (June 1997) (reproduced at App. 1-4 for the convenience of the Court).

American Medical Association
Physicians dedicated to the health of America

[LOGO]

AMA Board of Trustees FACT SHEET on HR 1122

1. Why did AMA support HR 1122?

AMA supported HR 1122 because, in the Board's view, "partial birth abortion" or intact D&X is ethically wrong, and it could not otherwise be restricted. Leaders of the profession, like former Surgeon General C. Everett Koop and medical ethicist Edmund Pellegrino oppose use of the procedure, as do most physicians and most members of the public.

In addition, AMA's expert panel, which included an ACOG representative, could not find "any" identified circumstance where it was "the only appropriate alternative."

Finally, by giving its support in exchange for changes in the legislation, AMA was able to substantially improve the Federal law and the law in the many states which are using, and passing, the Federal model.

2. Why is Intact D&X ethically wrong? How is it different from other destructive abortion procedures?

The procedure is ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed *outside* of the womb. The "partial birth" gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body.

3. Does the Board endorse criminalization of "medical practice" by supporting HR 1122?

In the Board's view, Intact D&X is not an accepted "medical practice," so the answer is no. There is no consensus among obstetricians about its use, and the Board's expert scientific report recommends against its use. It has never been subject to even a minimal amount of the normal medical practice development. It is not in the medical text books.

The AMA policy opposing the criminalization of medical practice is aimed primarily at preventing the prosecution (as recently occurred in New York) of physicians who have made serious, unintentional errors. In contrast, society has a long tradition of legislating, and criminalizing, certain abortion procedures, e.g., elective third trimester abortions. The profession has, in general, *not* opposed those efforts and the profession has supported criminal restrictions on improper "medical" procedures, such as female genital mutilation.

4. What changes were made in HR 1122?

The amendments obtained by the AMA were substantial and they were the maximum changes that could be obtained. *Without* the changes:

> (a) a physician doing an Intact D&X because he or she believes there may be a risk to the mother's life would have to show that *"no other procedure would [have] suffice[d]"* to protect the mother, a difficult burden under any circumstance. The AMA changes entirely *deleted* the "no other procedure would suffice" requirement. When a woman is endangered by her pregnancy, her physician *retains the discretion* to choose this procedure over other procedures that might also be available.

> (b) a physician would *not* have had the right to halt any prosecution in order to obtain review by an *independent medical practice board* of the appropriateness of the physician's conduct. That right is now guaranteed by AMA's changes.
>
> (c) a physician *intending to do a delivery* who encountered emergency circumstances that in his or her judgment required use of the procedure would have been subject to the law. He or she now has *complete discretion* to do whatever is necessary for the life *or* health of the woman without any concern for the statute. It does not apply.
>
> (d) a physician doing certain *other* kinds of abortion procedures might have been concerned about the legislation. It is clear beyond question as a result of AMA's changes that the legislation covers *only* Intact D&X.

5. Can the legislation be read as covering other abortion techniques?

The "partial birth abortion" legislation is by its very name aimed exclusively at a procedure by which a "living fetus" is "intentionally and deliberately" given "partial birth" and "delivered" "for the purpose of" killing it. There is no other abortion procedure which could be confused with that description.

Throughout the debate over the bill in Congress, and in the press, *only* the procedure known as Intact D&X was described as being covered by the bill. Any extension of the bill would be patently unconstitutional. Notwithstanding ACOG's objection to the use of non "medical"

terms, ACOG has conceded that the sponsors' intent is clear and limited: "However, based on legislative testimony, ACOG believes the intent of the Federal ban is to criminalize *an* abortion technique . . . which *some* practitioners have termed Intact Dilation and Extraction (Intact D&X)." ACOG Factsheeet, April 14, 1997 (emphasis added).

June 1997

Advocacy & Communications:

AMA Supports H.R. 1122 As Amended

"Partial-Birth Abortion Ban Act of 1997"

(Washington – May 20) – Nancy W. Dickey, MD, Chair of the AMA Board of Trustees issued the following statement:

> The American Medical Association Board of Trustees has determined to support H.R. 1122 because it has now been significantly changed to substantially meet the criteria which the Board established for any abortion legislation.
>
> Consistent with an expert report requested by AMA's House of Delegates last December and also forwarded to the AMA House last week for consideration at its June meeting, H.R. 1122 now narrowly defines the procedure to be restricted – a procedure for which AMA's expert panel could not find "any identified situation" in which it was "the only appropriate procedure to induce abortion" – and it broadens the exceptions.
>
> The changed language in the bill now: (a) makes it clear beyond any question that the accepted abortion procedure known as dilation and evacuation (also referred to as "D&E") is not covered by the bill, (b) permits the procedure to save the life of the mother without any obligation to show that "no other procedure would suffice," and (c) does not restrict use of the procedure for physicians intending a delivery at the outset, i.e., it can be done as necessary in their best medical judgment.

In addition, as also required by our legislative criteria letter, a physician will be entitled to stay any criminal proceeding in order to obtain expert review by the state medical board of any questioned conduct under the bill for use at trial.

As amended, H.R. 1122 is now a bill which impacts only a particular and broadly disfavored – both by experts and the public – abortion procedure. It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development. The bill has no impact on a woman's right to choose an abortion consistent with Roe v. Wade. Indeed, the procedure differs materially from other abortion procedures which remain fully available in part because it involves the partially delivered body of the fetus which is outside of the womb.

H.R. 1122 is serving as a model for many state legislatures and it is vitally important that the improvements which have been made become a part of the broader legislative process.

Advocacy & Communications

Letter to *The New York Times*
regarding AMA support of H.R. 1122

"Partial-Birth Abortion Ban Act of 1997"

The following letter from AMA Executive Vice President P. John Seward, MD was sent to *The New York Times:*

May 30, 1997

Letters to the Editor
The New York Times
229 W. 43rd Street
New York, NY 10036
Via Fax: 212-556-3622

Dear Editor:

There is no civility and very little truth in abortion politics. At the extreme ends of both sides – like the Frank Rich column about the AMA (Op. Ed. May 29, 1997) – there is only hysterical distortion designed to distract from the real issue.

The issue is not the AMA – which has been described by David Kessler as a "hero" of the anti-tobacco movement and whose Medicare policy was recently applauded in an editorial by this newspaper. The issue is whether the partial delivery of a living fetus for the purpose of killing it outside of the womb ought to be severely restricted. We believe, as a matter of ethical principle, it should rarely if ever be done. And although we also believe physicians should have broad discretion in medical matters, both this procedure and assisted suicide (as

well as female genital mutilation and lobotomies) can and should be regulated if the profession won't do it. And since there are safe, and indeed safer, abortion alternatives, we supported the Santorum bill as amended.

AMA's congressional advocacy is derived exclusively from the profession's values, especially the patient-physician relationship. But we cannot control the timing of the Congressional agenda. Our letters on abortion and Medicare – both public documents – went the same day because the Santorum bill ultimately came up the day that Congress had asked everyone – doctors, hospitals, home health care providers, insurance companies – to deliver their views on Medicare legislation. The Medicare letter went to 125 Congressional leaders, including Democratic leaders. It is similar to dozens of letters received on or about that same day from the other interested groups. Frank Rich could not be more wrong.

If it is just the Republicans we are trying to persuade we certainly would not have (a) delivered one day later a letter to Senator Kennedy supporting his efforts to expand access to care for children through an increased tobacco tax that the Republican leadership vigorously opposed, (b) stood one month earlier on the steps of the Capitol with Henry Waxman, demanding that Congress enact a lengthy anti-tobacco agenda, or (c) delivered on May 21 a letter to Representatives Kildee and Stark supporting ERISA reform which the Republicans

generally oppose, or engaged in countless other activities that defy partisan identification.

Sincerely,

P. John Seward, MD

App. 10

American Medical Association
Physicians dedicated to the health of America

[LOGO]

Statement

For Response Only **October 21, 1999**

"U.S. Senator Rick Santorum (R-PA) has reintroduced a bill that would ban intact dilation and extraction. The American Medical Association (AMA) has previously stated our opposition to this procedure. We have not changed our position regarding the use of this procedure.

"The AMA has asked Sen. Santorum to remove the criminal sanctions from his bill, but such a change has not been made. For this reason we do not support the bill."

App. 11

American Medical

NEWS

AMERICAN MEDICAL ASSOCIATION
NOVEMBER 20, 1995
VOLUME 38 – NUMBER 43

Outlawing abortion method

Veto-proof majority in House votes to prohibit late-term procedure

By Diane M. Gianelli
AMNEWS STAFF

WASHINGTON – His strategy was simple: Find an abortion procedure that almost anyone would describe as "gruesome," and force the opposition to defend it.

When Rep. Charles T. Canady (R. Fla.) learned about "partial birth" abortions, he was set.

He and other anti-abortion lawmakers launched a congressional campaign to outlaw the procedure.

Following a contentious and emotional debate, the bill passed by an overwhelming – and veto-proof – margin: 288-139. It marks the first time the House of Representatives has voted to forbid a method of abortion. And although the November elections yielded a "pro-life" infusion in both the House and the Senate, massive cross-over voting occurred with a significant number of "pro-choice" representatives voting to pass the measure.

The controversial procedure, done in second and third-trimester pregnancies, involves an abortion in which the provider, according to the bill, "partially

vaginally delivers a living fetus before killing the fetus and completing the delivery."

"Partial birth" abortions, also called "intact D&E" (for dilation and evacuation), or "D&X" (dilation and extraction) are done by only a handful of U.S. physicians, including Martin Haskell, MD, of Dayton, Ohio, and, until his recent death, James T. McMahon, MD, of the Los Angeles area. Dr. McMahon said in a 1993 *AMNews* interview that he had trained about a half-dozen physicians to do the procedure.

The procedure usually involves the extraction of an intact fetus, feet first, through the birth canal, with all but the head delivered. The surgeon forces scissors into the base of the skull, spreads them to enlarge the opening, and uses suction to remove the brain.

The procedure gained notoriety two years ago, when abortion opponents started running newspaper ads that described and illustrated the method. Their goal was to defeat an abortion rights bill then before Congress on grounds it was so extreme that states would have no ability to restrict even late-term abortions on viable fetuses. The bill went nowhere but strong reaction to the campaign prompted anti-abortion activists to use it again.

They drafted a bill that would ban the procedure, after considering a number of other options. An Ohio law passed earlier this year, for instance, bans "brain suction" abortions, except when all other methods would pose a greater risk to the pregnant woman. It has been enjoined pending a challenge.

Mixed feelings in medicine

The procedure is controversial in the medical community. On the one hand, organized medicine bristles at the notion of Congress attempting to ban or regulate any procedures or practices. On the other hand, even some in the abortion provider community find the procedure difficult to defend.

"I have very serious reservations about this procedure," said Colorado physician Warren Hern, MD. The author of *Abortion Practice*, the nation's most widely used textbook on abortion standards and procedures. Dr. Hern specializes in late-term procedures.

He opposes the bill, he said, because he thinks Congress has no business dabbling in the practice of medicine and because he thinks this signifies just the beginning of a series of legislative attempts to chip away at abortion rights. But of the procedure in question he says, "You really can't defend it. I'm not going to tell somebody else that they should not do this procedure. But I'm not going to do it."

Dr. Hern's concerns center on claims that the procedure in late-term pregnancy can be safest for the pregnant women, and that without this procedure women would have died. "I would dispute any statement that this is the safest procedure to use," he said.

Turning the fetus to a breech position is "potentially dangerous," he added. "You have to be concerned abut causing amniotic fluid embolism or placental abruption if you do that."

Pamela Smith, MD, director of medical education, Dept. of Ob-Gyn at Mt. Sinai Hospital in Chicago, added two more concerns: cervical incompetence in subsequent pregnancies caused by three days of forceful dilation of the cervix and uterine rupture caused by rotating the fetus within the womb.

"There are absolutely no obstetrical situations encountered in this country which require a partially delivered human fetus to be destroyed to preserve the life of the mother," Dr. Smith wrote in a letter to Canady.

Partial-Birth Abortion Ban Act of 1995

The bill: HR 1833

Summary: Bans abortions in which provider 'partially vaginally delivers a living fetus before killing the fetus and completing the delivery.'

Exceptions: 'Life of mother' and physician belief that no other procedure would suffice as "affirmative defense" to prosecution or civil action.

Penalties: Possibility of suits, fines and/or imprisonment of up to two years.

Proponents: Procedure is medically and morally indefensible.

Opposition: Congress has no business legislating medical standards and procedures; bill begins erosion *of* abortion rights.

Abortion

The procedure also has its defenders. The procedure is a "well-recognized and safe technique by those who provide abortion care," Lewis H. Koplik, MD, an Albuquerque, N.M., abortion provider, said in a statement that appeared in the *Congressional Record*.

"The risk of severe cervical laceration and the possibility of damage to the uterine artery by a sharp fragment of calvarium is virtually eliminated. Without the release of thromboplastic material from the fetal central nervous system into the maternal circulation, the risk of coagulation problems, DIC [disseminated intravascular coagulation], does not occur. In skilled hands, uterine perforation is almost unknown," Dr. Koplik said.

Bruce Ferguson, MD, another Albuquerque abortion provider, said in a letter released to Congress that the ban could impact physicians performing late-term abortions by other techniques. He noted that there were "many abortions in which a portion of the fetus may pass into the vaginal canal and there is no clarification of what is meant by 'a living fetus.' Does the doctor have to do some kind of electrocardiogram and brain wave test to be able to prove their fetus was not living before he allows a foot or hand to pass through the cervix?"

Apart from medical and legal concerns, the bill's focus on late-term abortion also raises troubling ethical issues. In fact, the whole strategy, according to Rep. Chris Smith (R. N.J.), is to force citizens and elected officials to move beyond a philosophical discussion of "a woman's

right to choose," and focus on the reality of abortion. And, he said, to expose those who support "abortion on demand" as "the real extremists."

Another point of contention is the reason the procedure is performed. During the Nov. 1 debate before the House, opponents of the bill repeatedly stated that the procedure was used only to save the life of the mother or when the fetus had serious anomalies.

Rep. Vic Fazio (D. Calif.) said, "Despite the other side's spin doctors – real doctors know that the late-term abortions this bill seeks to ban are rare and they're done only when there is no better alternative to save the woman, and, if possible, preserve her ability to have children."

Dr. Hern said he could not imagine a circumstance in which this procedure would be safest. He did acknowledge that some doctors use skull-decompression techniques, but he added that in those cases fetal death has been induced and the fetus would not purposely be rotated into a breech position.

Even some physicians who specialize in this procedure do not claim the majority are performed to save the life of the pregnant woman.

In his 1993 interview with *AMNews*, Dr. Haskell conceded that 80% of his late-term abortions were elective. Dr. McMahon said he would not do an elective abortion after 26 weeks. But in a chart he released to the House Judiciary Committee, "depression" was listed most often as the reason for late-term nonelective abortions with

maternal indications. "Cleft lip" was listed nine times under fetal indications.

The accuracy of the article was challenged, two years after publication, by Dr. Haskell and the National Abortion Federation, who told Congress the doctors were quoted "out of context," *AMNews* Editor Barbara Bolsen defended the article, saying *AMNews* "had full documentation of the interviews, including tape recordings and transcripts."

Bolsen gave the committee a transcript of the contested quotes, including the following, in which Dr. Haskell was asked if the fetus was dead before the end of the procedure.

"No it's not. No, it's really not. A percentage are for various numbers of reasons. Some just because of the stress – intrauterine stress during, you know, the two days that the cervix is being dilated. Sometimes the membranes rupture and it takes a very small superficial infection to kill a fetus in utero when the membranes are broken.

"So in my case, I would say probably about a third of those are definitely are [sic] dead before I actually start to remove the fetus. And probably the other two-thirds are not," said Dr. Haskell.

In a letter to Congress before his death, Dr. McMahon stated that medications given to the mother induce "a medical coma" in the fetus, and "there is neurological fetal demise."

But Watson Bowes, MD, a maternal-fetal specialist at University of North Carolina, Chapel Hill, said in a letter

to Canady that Dr. McMahon's statement "suggests a lack of understanding of maternal-fetal pharmacology. . . . Having cared for pregnant women who for one reason or another required surgical procedures in the second trimester, I know they were often heavily sedated or anesthetized for the procedures, and the fetuses did not die."

Next move in the Senate

At *AMNews* press time, the Senate was scheduled to debate the bill. Opponents were lining up to tack on amendments, hoping to gut the measure or send it back to a committee where it could be watered down or rejected.

In a statement about the bill, President Clinton did not use the word "veto." But he said he "cannot support" a bill that did not provide an exception to protect the life and health of the mother. Senate opponents of the bill say they will focus on the fact that it does not provide such an exception.

The bill does provide an affirmative defense to a physician who provides this type of abortion if he or she reasonably believes the procedure was necessary to save the life of the mother and no other method would suffice.

But Rep. Patricia Schroeder (D. Colo.) says that's not sufficient. "This means that it is available to the doctor after the handcuffs have snapped around his or her wrists, bond has been posted, and the criminal trial is under way," she said during the House debate.

Canady disagrees. "No physician is going to be prosecuted and convicted under this law if he or she reasonably believes the procedure is necessary to save the life of the mother."

Organized medicine positions vary

The physician community is split on the bill. The California Medical Assn., which says it does not advocate elective abortions in later pregnancy, opposes it as "an unwarranted intrusion into the physician-patient relationship." The American College of Obstetricians and Gynecologists also opposes it on grounds it would "supersede the medical judgment of trained physicians and . . . would criminalize medical procedures that may be necessary to save the life of a woman," said spokeswoman Alice Kirkman.

The AMA has chosen to take no position on the bill, although its Council on Legislation unanimously recommended support. AMA Trustee Nancy W. Dickey, MD, noted that although the board considered seriously the council's recommendations, it ultimately decided to take no position, because it had concerns about some of the bill's language and about Congress legislating medical procedures.

Meanwhile, each side in the abortion debate is calling news conferences to announce how necessary or how ominous the bill is. Opponents highlight poignant stories of women who have elected to terminate wanted pregnancies because of major fetal anomalies.

Rep. Nita Lowey (D. N.Y.) told the story of Claudia Ames, a Santa Monica woman who said the procedure had saved her life and saved her family.

Ames told Lowey that six months into her pregnancy, she discovered the child suffered from severe anomalies that made its survival impossible and placed Ames' life at risk.

The bill's backers were "attempting to exploit one of the greatest tragedies any family can ever face by using graphic pictures and sensationalized language and distortions," Ames said.

Proponents focus on the procedure's cruelty. Frequently quoted is testimony of a nurse. Brenda Shafer, RN, who witnessed three of these procedures in Dr. Haskell's clinic and called it "the most horrifying experience of my life.

"The baby's body was moving. His little fingers were clasping together. He was kicking his feet." Afterwards, she said, "he threw the baby in a pan." She said she saw the baby move. "I still have nightmares about what I saw."

Dr. Hern says if the bill becomes law, he expects it to have "virtually no significance" clinically. But on a political level, "it is very, very significant."

"This bill's about politics," he said, "it's not about medicine."

American Medical

NEWS

AMERICAN MEDICAL ASSOCIATION •
MARCH 3, 1997
• VOLUME 48 • NUMBER 9

Medicine adds to debate on late-term abortion

ACOG draws fire for saying procedure 'may' be best option for some

By Diane M. Gianelli
AMNEWS STAFF

WASHINGTON – As Congress and state legislatures consider banning a procedure opponents call "partial birth" abortion, the medical community is conducting its own appraisal of this controversial late-term abortion procedure.

The American College of Obstetricians and Gynecologists weighed in with an opinion from its Executive Board in January, saying it could identify "no circumstances under which this procedure would be the only option to save the life of the mother or preserve the health of the woman."

It added, however, that the procedure, which ACOG called intact dilation and extraction (D&X) and others call intact dilation and evacuation (D&E), "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances, can make this decision."

Opinion comes under fire

ACOG was immediately taken to task by a group of physicians who oppose the procedure.

By endorsing a practice "for which no peer-reviewed or safety data exist," ACOG appears to be violating its own standards, said members of PHACT (Physicians Ad Hoc Coalition for Truth), a group of about 400 physicians, many of whom are also ACOG members.

This statement "clearly does not represent a consensus among the nation's obstetricians and gynecologists as to the safety or appropriateness, under any circumstances, of partial birth abortion," the PHACT letter said. It added that it found it "unusual that PHACT, a coalition of doctors formed for no other reason than to investigate medical claims made about partial-birth abortion, was not invited to participate in these deliberations."

ACOG President Fredric D. Frigoletto, MD, in an interview, maintained that the board did not "endorse" the procedure. "There are no data to say that one of the procedures is safer than the other," he said. When asked why the statement said the procedure "may be the best" in some cases, Dr. Frigoletto answered, "or it may not be."

William Stalter, MD, an Ohio ob-gyn, said he feels let down by his professional organization.

ACOG, he said, "is supposed to be our standard-bearer for high-quality care in obstetrics and gynecology. And it's supposed to be the watchdog [against] procedures that are poorly conceived or unproven. Yet here

they're defending a procedure that is virtually unstudied," said Dr. Stalter, a professor of obstetrics and gynecology at Wright State University in Dayton.

Dr. Frigoletto, in a letter responding to PHACT's complaints, said a task force drafted the policy statement that was amended and unanimously adopted by ACOG's executive board in January. "Clearly our organizations do not agree on the content of the statement," he wrote. "I hope we can respect these differences."

Meanwhile, the American Medical Association is also looking at the issue. Although it opted not to take a position when a federal bill to ban the procedure was considered last year, several members of the AMA House of Delegates pressed for a change in that position in the AMA's Interim Meeting in December. The house voted to have the AMA study the issue and evaluate the medical evidence before determining whether the practice conformed to the standards of good medical practice.

The AMA board discussed the issue at its February meeting, said AMA Trustee John C. Nelson, MD, a Salt Lake City ob-gyn. But it came to no conclusions.

"I'm not sure exactly what we'll say," he said. "If the medical literature or our colleagues cannot justify this procedure, we'll say we shouldn't do it. If in fact we can justify it, we'll say we could do it."

What medical groups have in common when viewing a potential ban on the procedure is a reluctance to allow Congress to meddle in medical matters. But this stance invites criticism from those who point out that many medical groups supported congressional efforts to pass

laws requiring insurers to cover minimum stays for childbirth deliveries and banning another controversial procedure called female circumcision or genital mutilation.

Looking for the science

The late-term abortion procedure is difficult to study, Dr. Nelson said, because there are no published reports on it. "We want to have the information so we can come up with a considered and reasoned viewpoint," Dr. Nelson said. He added that the AMA "will have a board report on the issue in June."

Without published data and peer-reviewed studies on the procedure, it's hard to reach clear findings about it. Now that Congress is taking a second look at a bill to ban the procedure and at least 25 states have introduced similar legislation, safety questions are once again being raised. The bill to ban it passed in both the Senate and the House last year, but it was vetoed by President Clinton.

Those who perform the procedure say it is safer for the woman and more convenient for the surgeon. Although the whole procedure takes three days, to allow for the women to come in for frequent laminaria insertions to dilate her cervix, the actual operation is scheduled on an outpatient basis and takes only five to 15 minutes.

Some providers say this method is safer than the classic D&E procedure in which the fetus is dismembered in the womb, leaving the mother at greater risk for internal perforations caused by either the slip of the surgeon's

instruments or bones from the fetus broken inside her body.

They claim that the intact D&E, because it avoids much of the sharp instrumentation and bone tears, is the procedure of choice for late-term abortions to preserve the woman's future fertility.

At a news conference this fall, the president spoke movingly of the women who chose this method to end their wanted pregnancies because of unexpected fetal anomalies. This procedure, he said, allowed them the chance to have another baby.

Opponents of the procedure assert, however, that the claim is without medical merit, and note that one of the five women at Clinton's veto ceremony had five miscarriages after her intact D&E. The procedure, opponents say, is potentially risky and actually contraindicated for fertility enhancement.

Late-term abortion options

A better option, they maintain, is to deliver the fetus by induction, using prostaglandin or pitocin to ripen the cervix and induce labor. Fetus demise can be induced beforehand.

Some also question the necessity of killing the fetus through brain suction or any other method if it has a condition incompatible with life and suggest it is "more humane" to have the physician induce labor and let the child die naturally.

Critics also say turning the fetus to a breech position can cause amniotic fluid embolism, placental abruption or uterine rupture.

And they maintain that the forcible dilation necessary to prepare the women's cervix for the procedure risks creating an "incompetent cervix," which could prevent a woman from carrying future pregnancies to term.

Diana Grossheim, from Huntington Beach, Calif., may be one of those women. Grossheim had an intact D&E in 1995. She now has an incompetent cervix.

When Grossheim's almost 21-week-old fetus died in utero, she said her physician told her she had two choices: labor, which was described as up to 48 hours of torture, or intact D&E, which her doctor described as "more merciful."

Grossheim said the procedure was "three days of pure hell" – both physical and mental.

She had to stay in a hotel and go back and forth to the clinic for laminaria changes. She was afraid she might deliver the baby in the hotel. On her second night, the pain was terrible – she was vomiting, cramping and screaming all night.

When her daughter was finally delivered, Grossheim said she and her husband didn't understand why she had such a flat head. If they were told about the brain suction procedure, it wasn't in terms she could understand, said the high school math teacher.

When Grossheim became pregnant again, she was told during a routine ultrasound in her 23rd week that she had an incompetent cervix and had to go on bed rest

for the remainder of her pregnancy. She delivered a healthy boy at 37 weeks, but still remembers the second half of her pregnancy as uncomfortable and frightening – thinking the baby would come any time and would die, too. She was heavily medicated and having contractions around the clock.

She's now 35 years old and would like to get pregnant again. But she can't afford to hire someone to watch her child while she spends her next pregnancy in bed. And she fears her chances of carrying to term are slim.

In retrospect, Grossheim wishes she had chosen the labor option. She would have felt safer in the hospital, where her pain could have been controlled and her fear of delivering alone eliminated. And she doesn't see any justification for the intact D&E procedure.

"Now that I've been through actual labor and delivery," she said, "I think it was much easier than what I went through."

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No. 99-830

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In The

Supreme Court of the United States

DON STENBERG, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Eighth Circuit

BRIEF *AMICUS CURIAE* OF FAMILY FIRST, IN SUPPORT OF PETITIONERS

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INTEREST OF THE AMICUS[1]

Amicus curiae, Family First, is a 501(c)(3), non-profit, non-partisan research and educational organization dedicated to strengthening Nebraska families. Established in association with Dr. James Dobson's Focus on the Family, Family First links experts in law, medicine, media and education to help families deal with the problems facing our communities, our State and our Nation. The mission of Family First is to equip and encourage the people of Nebraska to create communities where families are valued, nurtured and strengthened. Consistent with that mission and the respect for human life which that mission implies, Family First submits the following Brief in support of petitioners and in defense of the Nebraska partial-birth abortion act.

SUMMARY OF ARGUMENT

The stark and somber issue presented by this case is whether the State of Nebraska has the constitutional authority to ban a cruel and grotesque abortion procedure defined legally as "partial-birth abortion" and known medically as dilation and extraction (D & X) or intact dilation and evacuation (intact D & E). In this procedure, as practiced and described by respondent herein, the physician vaginally delivers a living unborn

[1] Counsel for the *amicus* authored the Brief in whole. No person or entity other than the *amicus* has made a monetary contribution to the preparation or submission of the Brief. This Brief is filed with the consent of the parties. Letters of consent have been filed with the Clerk.

child up to the head, then either crushes the child's skull with forceps or pierces the child's skull with sharp instruments and suctions out the brains, killing the child. Without deciding whether Nebraska may prohibit the D & X procedure, for which neither the American College of Obstetricians nor the American Medical Association could find any justifiable medical purpose, the court of appeals held that the State's effort to end this abhorrent practice is unconstitutional because the language defining the offense is overbroad,[2] sweeping within its scope not only the rarely used D & X procedure, but also the conventional D & E procedure, the most commonly used technique for second-trimester abortions. *Carhart v. Stenberg*, 192 F.3d 1142, 1149-50 (8th Cir. 1999). Given this interpretation, the lower court concluded that the statute "imposes an undue burden on a woman's right to choose to have an abortion," and, therefore, is unconstitutional under this Court's decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). *Carhart*, 192 F.3d at 1153.

For the reasons set forth in petitioners' brief, *amicus curiae* believes that the court of appeals' reading of the

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[2] "Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. . . . [T]he term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." NEB. REV. STAT. § 28-326(9) (Supp. 1997).

statute is fundamentally flawed and that the statute, when properly and reasonably construed to apply only to the D & X procedure, is constitutional. But the efforts of the State of Nebraska and twenty-nine other States to vindicate their constitutional authority to proscribe a procedure that borders on infanticide have been largely unavailing because of the concerns expressed by physicians (and accepted by courts) that partial-birth abortion statutes are either overbroad, reaching constitutionally protected abortion procedures, or vague, arguably encompassing such procedures, or both. As a result of this asserted overbreadth or vagueness, physicians have claimed that they will be "chilled" in their abortion practice if these statutes are allowed to go into effect. Few of the physicians in these cases, however, actually perform the procedure which the statutes were intended to prohibit, the D & X. Upwards of sixty named plaintiff physicians have challenged twenty-one partial-birth abortion statutes to date. Yet, only three of these physicians – Dr. Marvin Haskell, Dr. Dennis Christensen, and respondent, Dr. Leroy Carhart – forthrightly and unequivocally admit to using the D & X procedure. And of the three courts of appeals which have reviewed statutes affecting the conduct of these physicians, only one even reached the question as to whether the State could ban the D & X procedure, and that court held that it could. *Compare Hope Clinic v. Ryan*, 195 F.3d 857 (7th Cir. 1999) (*en banc*) (upholding Wisconsin partial-birth abortion statute), *petitions for certiorari pending*, Nos. 99-1156, 99-1177, *with Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187, 197-203 (6th Cir. 1997) (not deciding whether the D & X procedure could be prohibited, but holding that "the

Act's ban on the D & X procedure is unconstitutional because the definition of the procedure encompasses the more commonly employed D & E procedure and, therefore, places a substantial obstacle in the path of a woman seeking pre-viability abortions), *cert. denied*, 118 S.Ct. 1347 (1998), and *Carhart v. Stenberg*, 192 F.3d 1142, 1146 n.4 (8th Cir. 1999) (not deciding "whether the law creates an undue burden by prohibiting the D & X procedure"). Overbreadth and vagueness claims thus not only have resulted in the invalidation of partial-birth abortion statutes in many States where none of the plaintiff physicians challenging them performs (or intends to perform) the D & X procedure, but also have effectively prevented courts in other States from deciding whether the D & X procedure may be prohibited in those few instances where it *is* used.[3]

Until recently, there was no practical way of knowing whether physicians' alleged concerns about the scope and application of partial-birth abortion statutes to conventional first and second-trimester abortion procedures

[3] Dr. Carhart testified that he actually performs only 10-20 D & X abortions per year. *See Carhart v. Stenberg*, 11 F. Supp.2d 1099, 1121 (D. Neb. 1998). In the challenge to the Wisconsin partial-birth abortion case, Dr. Christensen testified that he performs only two or three D & X procedures per year. *See Planned Parenthood of Wisconsin v. Doyle*, 44 F. Supp.2d 975, 979 (W.D. Wis. 1999) ("Among the plaintiff physicians, only Christensen regularly performs the D & X procedure and he performs just 2-3 such procedures each year"). And Dr. Haskell, who invented the procedure and frequently uses it, admitted in the same case that "the D & X procedure is never medically necessary to save the life or preserve the health of a woman." *Id.* at 980.

were genuine or feigned, real or illusory, rational or irrational. Fortunately, that is no longer the case. There is now a large body of official abortion reporting data from those States whose partial-birth abortion laws have been allowed to go into effect which proves beyond question that the professed fears of physicians regarding the impact of these laws have no foundation in fact. This data, which was not available at the time the district court entered its permanent injunction on July 2, 1998, establishes that enactment of partial-birth abortion statutes has neither prevented physicians from performing conventional first and second-trimester abortion procedures, including suction curettage (vacuum aspiration) and dilation and evacuation (D & E), nor resulted in an increase of induction (instillation) procedures. There is also no evidence that these statutes have compelled physicians to send their patients out of State for conventional abortion procedures or have caused them to modify their abortion techniques in any way that would jeopardize the health of their pregnant women patients.[4]

Amicus curiae seeks to bring this critical data to the Court's attention because it dispels the fears that enforcement of a partial-birth abortion act will prevent women

[4] During the two weeks that the Wisconsin partial-birth abortion act was in effect, one of the plaintiff physicians, Dennis Christensen, issued a press release stating that he would comply with the Act as he understood it "only by altering his procedure in a way that would impose greater health risks on women." *Planned Parenthood of Wisconsin v. Doyle*, 44 F. Supp.2d 975, 981 (W.D. Wis. 1999). At the trial on the permanent injunction, Dr. Christensen acknowledged that during this two-week period, the rate of complications from abortions did not go up in a "statistically significant fashion." *Id.*

from obtaining conventional first and second-trimester abortions and enables the Court to focus on the ultimate issue in this case, whether the State of Nebraska, or any State, may ban the D & X procedure.

ARGUMENT

PLAINTIFF'S OVERBREADTH AND VAGUENESS CLAIMS SHOULD BE REJECTED BECAUSE OFFICIAL STATE ABORTION REPORTING DATA PROVES THAT THE ENACTMENT OF PARTIAL-BIRTH ABORTION STATUTES HAS NOT PREVENTED PHYSICIANS FROM PERFORMING CONVENTIONAL FIRST AND SECOND-TRIMESTER ABORTION PROCEDURES, INCLUDING SUCTION CURETTAGE AND DILATION AND EVACUATION, IN THOSE STATES WHERE THE STATUTES HAVE BEEN ALLOWED TO GO INTO EFFECT.

In his complaint, respondent alleged that "[b]ecause the definition of so-called 'partial-birth abortion' is both vague and broad, physicians may face prosecution for performing what are the safest and most common abortion procedures used after the first trimester of pregnancy and before fetal viability." Complaint, ¶ 2.[5] In his

[5] *See also* ¶ 39: "Because of the breadth and ambiguity in the Act's definition of 'partial-birth abortion,' the Act could reach nearly every abortion performed after the first trimester, with the exception of hysterotomy or hysterectomy." ¶ 42: "The Act fails to give physicians fair warning as to which abortion procedures are made criminal. The Act forces physicians to guess whether their performance of a safe, accepted medical procedure will subject them to imprisonment and loss of their medical license. This will chill physicians from providing safe abortion procedures after the first trimester."

testimony at the hearing on the preliminary injunction, respondent expressed concern that the Act also applied to first-trimester abortion procedures as well, specifically vacuum aspiration (suction curettage). J. Tr. at 352, 360-65. Respondent's "fears" about the scope and application of the Nebraska partial-birth abortion act can be shown to have no foundation in fact.

Thirty States have enacted statutes prohibiting partial-birth abortions.[6] Abortion providers have challenged the statutes in twenty-one of these States and have succeeded in preventing eighteen of them from going into effect.[7] This Brief examines official abortion reporting

[6] Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Montana, Nebraska, New Jersey, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia and Wisconsin.

[7] Statutes have been challenged in Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Illinois, Iowa, Kentucky, Louisiana, Michigan, Missouri, Montana, Nebraska, New Jersey, Ohio, Rhode Island, Virginia, West Virginia and Wisconsin. Enforcement of the statutes in all but three of these States has been enjoined. In two of those States, Alabama and Georgia, the statutes have been construed to apply only to post-viability abortions. *See Summit Medical Associates, P.C. v. James*, 984 F. Supp. 1404, 1414-15 (M.D. Ala. 1998) (Attorney General interpretation), *aff'd in part, rev'd in part and remanded with directions*, 180 F.3d 1326 (11th Cir. 1999) (discussing Eleventh Amendment issues only); *Midtown Hospital v. Miller*, Civil Action No. 1:97-CV-1786-JOF (N.D. Ga. Sep. 2, 1998) (consent order). In the third State, Virginia, the law is in force by virtue of a stay order entered by the Fourth Circuit Court of Appeals from the district court's permanent injunction. *See Richmond*

data from five of the nine States whose partial-birth abortion statutes have not been challenged (Indiana, Mississippi, South Carolina, South Dakota and Tennessee) and the one State whose statute has been allowed to go into effect during litigation (Virginia).[8]

Indiana, Mississippi and South Dakota all enacted partial-birth abortion bans that became effective on July 1, 1997. *See* IND. CODE ANN. § 16-18-2-267.5 (Michie 1998) (defining offense); § 16-34-2-1(b) (Michie Supp. 1999) (prohibition); MISS. CODE ANN. § 41-41-71 *et seq.* (1999); S.D. CODIFIED LAWS § 34-23A-27 *et seq.* (Michie Supp. 1999). None of these statutes has been construed by any state or federal court.

Medical Center for Women v. Gilmore, No. 98-1930 (4th Cir. Sep. 14, 1999) (staying injunction).

[8] Comparative abortion data is not available from the eighteen States whose partial-birth abortion acts have been enjoined, from the four States whose laws apply (or have been interpreted to apply) only to post-viability abortions (*see* n. 7, *supra*, for Alabama and Georgia, and *see also* KAN. STAT. ANN. § 65-6721 (Supp. 1999), and UTAH CODE ANN. § 76-7-310.5 (1999)), from one State (Oklahoma) which does not publish or disclose reported abortion data, and from one State (North Dakota) whose law was enacted too recently to allow for comparison. *See* SENATE BILL 2254 (1999 Session).

Of the six States whose reporting data is discussed in this Brief, four (Indiana, Mississippi, South Carolina and South Dakota) do not define the phrase "partially vaginally delivers a living fetus," while the other two (Tennessee and Virginia) define the phrase, as Nebraska does, to include a living fetus (or unborn child) *"or a substantial portion thereof."* *See* TENN. CODE ANN. § 39-15-209(a)(2) (1997); VA. CODE ANN. § 18.2-74.2(D) (Michie Supp. 1999).

A comparison of abortion data from these three States for the first half of 1997, when none of the statutes was in effect, to data for the second half of 1997, when all of these statutes were in effect, leaves no doubt that plaintiff's expressed fears of being prosecuted for performing conventional first and second-trimester abortion procedures (suction curettage and dilation and evacuation) are baseless.[9] In the words of Federal District Court

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[9] Rule 201 of the Federal Rules of Evidence permits a court to take judicial notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." FED. R. EVID. 201(b)(2). "[A] court may take judicial notice of records and reports of administrative bodies." *Mack v. South Bay Beer Distributors, Inc.*, 798 F.2d 1279, 1282 (9th Cir. 1986) (internal citation omitted). Judicial notice may be taken "at any stage of the proceedings," FED. R. EVID. 201(f), including on appeal. In *Barber v. Ponte*, 772 F.2d 982 (1st Cir. 1985) (*en banc*), *cert. denied*, 475 U.S. 1050 (1986), the First Circuit took judicial notice of census data and health statistics, including abortion reporting data, for the first time on appeal. *Id.* at 998-99 & nn. 4-16. Other circuits have taken judicial notice of census data on appeal, which is similar to the abortion reporting data which *amicus* seeks to bring to the Court's attention. *See Goins v. Allgood*, 391 F.2d 692, 697 (5th Cir. 1968); *Mitchell v. Rose*, 570 F.2d 129, 132, n.2 (6th Cir. 1978), *rev'd on other grounds*, 443 U.S. 545 (1979); *United States v. United Brotherhood of Carpenters & Joiners of America, Local 169*, 457 F.2d 210, 214 n.7 (7th Cir. 1972), *cert. denied*, 409 U.S. 851 (1972); *Parham v. Southwestern Bell Telephone Co.*, 433 F.2d 421, 426 n.4 (8th Cir. 1970); *United States v. Esquivel*, 88 F.2d 772, 726-27 (9th Cir. 1996), *cert. denied*, 519 U.S. 985 (1996); *Moore v. Comfed Savings Bank*, 908 F.2d 834, 841 n.4 (11th Cir. 1990). *Amicus* emphasizes that none of the state abortion reporting data from 1997 and 1998 discussed in this Brief would have been available at any stage of the proceedings in the district court, which entered its permanent injunction on July 2, 1998. The unavailability of this data at trial underscores the need for the

Judge Shabaz, "plaintiffs' alleged confusion concerning the meaning of the Act is a demon of their own creation." *Planned Parenthood of Wisconsin v. Doyle*, 44 F. Supp.2d 975, 985 (W.D. Wis. 1999), *aff'd*, 195 F.3d 857 (7th Cir. 1999) (*en banc*), *petitions for certiorari pending*, Nos. 99-1156, 99-1177. "Everyone understands what partial birth abortion is and what is not. It *is* the D & X procedure. It is *not* the suction curettage procedure, the induction procedure or the D & E procedure." *Id.* (emphasis in original). *See also Rhode Island Medical Society v. Whitehouse*, 66 F. Supp.2d 288, 295 (D. R.I. 1999) ("doctors recognize the difference between the D & E and the D & X"), *appeal stayed*, No. 99-2095 (1st Cir. Nov. 22, 1999). Review of this data allows the Court, in the words of the Seventh Circuit, "to perform a reality check" on the allegations that respondent would not be able to perform first or second-trimester abortion procedures if the Nebraska law were allowed to go into effect. *Hope Clinic v. Ryan*, 195 F.3d 857 at 870.

Indiana

The Indiana State Department of Health reported that 13,208 abortions were performed in 1997, of which 12,429 were suction curettage, 87 sharp curettage, 159 dilation and evacuation (D & E), and two intra-uterine prostaglandin instillation. *See* Appendix A-2.[10] The data

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Court to give this data the weight it deserves in evaluating plaintiff's claims of vagueness and overbreadth. The original documents authenticating the data set forth in the appendices have been lodged separately with the Clerk.

[10] In addition, there were 371 unknown procedures and 160 procedures not otherwise classified. Of the former, 193 (52.02%)

reflects that 46.92% of the suction curettage procedures (5,832 of 12,429), 42.25% of the sharp curettage procedures (37 of 87), 54.71% of the dilation and evacuation procedures (87 of 159), and neither of the prostaglandin instillation procedures were performed in the second half of the year, during which time the Indiana partial-birth abortion act was in effect. As this data shows, the partial-birth abortion act did not prevent physicians in Indiana from performing D & E's, nor did it cause them to substitute induction for D & E's (no inductions were performed in the second half of the year). Nor is there any evidence that physicians sought to avoid the D & E procedure by sending their patients out of State. Dilation and evacuation procedures accounted for 1.03% of all abortion procedures performed during the first six months of 1997 (72 of 6,950), when the partial-birth abortion act was *not* in effect, but 1.39% of all procedures performed during the second six months of 1997 (87 of 6,258), when the act *was* in effect. "These data," as the Seventh Circuit noted, "are incompatible with plaintiffs' *a priori* belief that the partial-birth abortion statutes will discourage the performance of the D & E procedure or cause the physician to substitute an inferior procedure." *Hope Clinic v. Ryan*, 195 F.3d 857, 870 (7th Cir. 1999) (*en banc*), *petitions for certiorari pending*, Nos. 99-1152, 99-1156 and 99-1177. In the eighteen months after the Indiana partial-birth abortion statute took effect, there were 286 D & E's, while in the eighteen months before the statute took effect, there were

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were performed in the second half of the year; of the latter, approximately 2/3 (109 of 160) were performed in the second half of the year.

263 D & E's. *See* INDIANA TERMINATED PREGNANCY REPORT 1996, Table 20 (Jan. 1998), and Appendix A-4. This certainly does not suggest that physicians in Indiana were "chilled" from performing D & E's by the enactment of the partial-birth abortion statute. Data from other States confirms the Seventh Circuit's sense that "partial-birth abortion statutes need not have [and, in fact, have not had] the baleful effect the plaintiffs foresee." *Id.*

Mississippi

The Mississippi State Department of Health reported that 4,325 abortions were performed in Mississippi in 1997, of which 2,494 were suction curettage, one sharp curettage, 1,788 dilation and evacuation (D & E), and 23 intra-uterine prostaglandin instillation. *See* MISSISSIPPI VITAL STATISTICS 1997, Table F3 at 43.[11] A breakdown of this data by procedure and month discloses that 47.95% of the suction curettage procedures (1,196 of 2,494), 41.94% of the dilation and evacuation procedures (750 of 1,788), and

[11] In addition, there were 19 procedures not otherwise classified. All of these procedures are defined in the MISSISSIPPI STATE BOARD OF HEALTH'S HANDBOOK ON REGISTRATION & REPORTING OF VITAL EVENTS: INDUCED TERMINATION OF PREGNANCY, Appendix A (January 1, 1999). Suction curettage (or vacuum aspiration) is described as a procedure in which "a flexible tube (cannula) is inserted into the uterine cavity [after the cervical canal has been dilated by the successive insertion of dilators], and the fetal and placental tissues are then suctioned out by an electric vacuum pump." Dilation and evacuation is described as a procedure "used most frequently in the second trimester" which "involves opening the cervix (dilation) and using primarily sharp techniques, but also suction and other instrumentation such as forceps for evacuation."

almost two-thirds of the prostaglandin instillation procedures (15 of 23) were performed in the second half of the year, during which time the Mississippi partial-birth abortion act was in effect. *See* Appendix B-4. Although the number of D & E's as a percentage of all abortions declined from 44.07% for the first six months of the year (1,038 of 2,355) to 38.07% for the second six months of the year (750 of 1,970), both the number of D & E's performed in the second half of the year (750) and the number of D & E's as a percentage of all abortions for the second half of 1997 (38.07%) leave little doubt that Mississippi's partial-birth abortion act has not prevented physicians in Mississippi from performing either first or second-trimester abortion procedures, including D & E's. Mississippi physicians would not have selected the D & E procedure as their method of choice in almost 40% of all the abortions they performed in the last six months of 1997 if they had been "chilled" in their practice by the enactment of the partial-birth abortion act. Moreover, the very small number of instillation procedures (15) and procedures not otherwise classified (9), which together account for roughly one percent of all abortions performed in Mississippi during the second half of 1997 (24 of 1,970) establishes that physicians in Mississippi did not substitute induction or some other procedure for the D & E procedure after the partial-birth abortion act became effective.

In 1998, the first full year after the Mississippi partial-birth abortion act took effect, almost one-third of all abortions performed in Mississippi (1,287 of 3,955) were D & E's. *See* MISSISSIPPI VITAL STATISTICS 1998, Table F3 at 43. This represents a slight decline from 1996, the last full

year before the partial-birth abortion act took effect, when approximately 37% of all abortions (1,553 of 4,206) were D & E's. *See* MISSISSIPPI VITAL STATISTICS 1996, Table F3 at 43. Nevertheless, the small number of instillation procedures (32) and procedures not otherwise classified (13), which together account for barely one percent of all abortion procedures performed in 1998 (45 of 3,955), suggests that Mississippi physicians did not substitute induction or some other procedure for the D & E procedure after the partial-birth abortion act became effective. But perhaps the most significant statistic is that more than 2,000 D & E's were performed in Mississippi in the eighteen months *after* the partial-birth abortion act became effective on July 1, 1997. *See* Appendix B-4 and MISSISSIPPI VITAL STATISTICS 1998, Table F3 at 43. In sum, there is no evidence whatsoever that physicians in Mississippi were in any way "chilled" in their practice from performing D & E's (or any other conventional abortion procedure) by the unchallenged partial-birth abortion act.

South Dakota

The South Dakota Department of Health reported that 919 abortions were performed in South Dakota in 1997, of which 702 were suction curettage and 217 were dilation and evacuation (D & E). *See* SOUTH DAKOTA VITAL STATISTICS & HEALTH STATUS 1997 at 67-68 & 77 (Figure 24).[12] A breakdown of this data by procedure and month reveals that 26.92% of the suction curettage procedures (189 of 702) and all but one of the dilation and evacuation

[12] No other abortion procedures were reported in 1997.

procedures (216 of 217) were performed in the second half of the year, during which time the South Dakota partial-birth abortion act was in effect. *See* Appendix C-2.[13] Quite obviously, the South Dakota partial-birth abortion act has not prevented physicians from performing D & E's in South Dakota. Remarkably, almost three times as many D & E's were performed in the eighteen months *after* the South Dakota partial-birth abortion act took effect (889 procedures) as in the eighteen months *before* the act took effect (307 procedures). *See* Appendix C-2, C-4.

Virginia

As the result of a stay of a preliminary injunction which stay was entered by a judge of the Fourth Circuit Court of Appeals on June 30, 1998, *see Richmond Medical Center for Women v. Gilmore*, 144 F.3d 326 (4th Cir. 1998) (Luttig, J., granting stay), the Virginia partial-birth abortion act (*see* VA. CODE ANN. § 18.2-74.2 (Michie Supp. 1999)) went into effect on July 1, 1998. The experience of physicians performing abortions in Virginia after the statute took effect completely belies the assertions of the plaintiff physicians at the hearing on the motion for a preliminary injunction that, in the words of the district

[13] That all but one of the D & E's were performed in the last four months of the year, when only 15 suction curettage procedures were performed, may have been attributable to the retirement of one abortion provider, who apparently preferred using suction curettage, and his replacement by another provider who prefers using the D & E procedure. The month of procedure was not stated for two suction curettage procedures.

court, "the Act is written so broadly and vaguely that a prosecutor could interpret the Act to include the procedures these physicians perform such as suction curettage and D & E [dilation and evacuation], as the plaintiffs perform them." *Richmond Medical Center for Women v. Gilmore*, 11 F. Supp.2d 795, 805 (E.D. Va. 1998). Accordingly, the plaintiffs' professed "fear [of] prosecution and the loss [of] their medical license to practice if they continue performing abortions in their normal course of procedure," *id.*, was shown to be groundless.

The Virginia Department of Health reported that 26,115 abortions were performed in Virginia in 1998, of which 24,920 were suction curettage, 14 sharp curettage, 268 dilation and evacuation (D & E), 11 intra-uterine saline instillation and 98 intra-uterine prostaglandin instillation. *See* Appendix D-4.[14] Of these figures, 48.71% of the suction curettage procedures (12,140 of 24,920), five of the fourteen sharp curettage procedures, 46.26% of the dilation and evacuation procedures (124 of 268) and approximately one-half of the instillation procedures (55 of 109) were performed in the second half of the year during which time the Virginia partial-birth abortion act was in effect. Dilation and evacuation procedures accounted for 1.07% of all abortions performed in the first six months (144 of 13,341) and 0.97% of all abortions performed in the last six months (124 of 12,773). Although the number of D & E's declined by 13.8% from the first half of the year to the second half of the year (144

[14] The Department of Health also reported three hysterectomies, two hysterotomies, 76 unknown procedures and 723 procedures not otherwise classified.

to 124), both the number of D & E's performed in the second half of the year (124), and the fact that the number of instillation procedures remained virtually unchanged from the first half of the year (54) to the second half of the year (55), again suggests, as in the case of Mississippi, that the partial-birth abortion act did not prevent physicians in Virginia from performing D & E's or force them to use instillation procedures to avoid the effect of the law. More D & E's were performed in the last six months of 1998 (124), when the partial-birth abortion act *was* in effect, than in the last six months of 1997 (121), when the law was *not* in effect. *See* Appendix D-4, D-7.

To summarize the foregoing data, almost 1,200 D & E's and more than 19,000 suction curettage procedures were performed in just four States in the first six months *after* their partial-birth abortion acts went into effect.[15] The physicians in those States were not "chilled" in their practice or prevented from performing conventional first and second-trimester abortion procedures, including suction curettage and dilation and evacuation. Moreover, the fact that only 70 instillation procedures were performed in these four States in the first six months after their partial-birth abortion acts took effect proves that physicians practicing in these States did not substitute instillation for dilation and evacuation.

Abortion data from South Carolina and Tennessee, where few D & E's were performed in 1997 either before

[15] Dilation and evacuation: Indiana (87); Mississippi (750); South Dakota (216); Virginia (124). Suction curettage: Indiana (5,832); Mississippi (1,196); South Dakota (189); Virginia (12,140).

or after enactment of their partial-birth abortion acts, confirms that the statutes in these States did not "chill" physicians from performing suction curettage procedures or force physicians to use instillation procedures in lieu of dilation and evacuation. Neither statute has been construed by any state or federal court.

South Carolina

The South Carolina partial-birth abortion act became effective on March 26, 1997. *See* S.C. CODE ANN. § 44-41-85 (Law Co-op. Supp. 1999). The South Carolina Department of Health & Environmental Control reported that 9,212 abortions were performed in South Carolina in 1997, of which 9,158 were suction curettage, two dilation and evacuation (D & E), one intra-uterine saline instillation and twenty intra-uterine prostaglandin instillation. *See* Appendix E-3.[16] The data shows that slightly less than three-fourths of the suction curettage procedures (6,631 of 9,158) and three-fourths of the instillation procedures (15 of 21), and both D & E's were performed in the last nine months of the year, during which time the South Carolina partial-birth abortion act was in effect. There is no evidence that the law led to an increase in the number of induction procedures (an average of two procedures per month before the law went into effect and 1 2/3 such procedures per month after the law went into effect) or prevented physicians from performing D & E's. Although no D & E's were performed in 1998, the first full year

[16] In addition, there were five unknown procedures and 26 procedures not otherwise classified.

after the partial-birth abortion act took effect, only 14 D & E's were performed in 1996, the last full year before the law took effect. *See* Appendix E-3. This represents less than one-sixth of one percent of all abortions performed in 1996 (9,326). The number of intra-uterine prostaglandin instillation procedures declined from 28 in 1996 to 10 in 1998, thus indicating that the partial-birth abortion statute, enacted in 1997, had no impact on the incidence of instillation procedures in South Carolina. *See* Appendix E-3.

Tennessee

The Tennessee partial-birth abortion act became effective on July 1, 1997. *See* TENN. CODE ANN. § 39-15-209 (1997). The Tennessee Department of Health reported that 18,283 abortions were performed in Tennessee in 1997, of which 18,212 were suction curettage, seven dilation and evacuation (D & E), 56 intra-uterine prostaglandin instillation and one intra-uterine saline instillation. *See* Appendix F-4.[17] The data indicates that 48.42% of the suction curettage procedures (8,819 of 18,212), three of the seven dilation and evacuation procedures, and 53.57% of the prostaglandin instillation procedures (30 of 56) and the saline instillation procedure were performed in the second half of the year, when the Tennessee partial-birth abortion act was in force. Although the number of instillation procedures as a percentage of the total number of abortions rose slightly from 0.276% (26 of

[17] There was one hysterectomy procedure and in six cases the procedure was unknown.

9,420) in the first half of the year to 0.338% (30 of 8,859) in the second half of the year,[18] there is no evidence that the law had any impact on the number of D & E's, forced physicians to do inductions instead of D & E's or made them refer their patients out of State because of the presence of the partial-birth abortion act. The statistics suggest that, like in South Carolina, few physicians in Tennessee used the D & E procedure in 1997. Significantly, in 1998, the first full year after the Tennessee partial-birth abortion act took effect, there were 66 D & E's, while in 1996, the last full year before the act took effect, there were only four. *See* Appendix F-8, F-9. A more than sixteen-fold increase in the number of D & E's hardly bespeaks evidence of "chilling." Whatever the reason for the increase, the enactment of the unchallenged partial-birth abortion statute obviously had no effect on physicians' choice of procedure.

Notwithstanding the lower court's conclusion that the Nebraska partial-birth abortion act encompasses both D & X procedures and D & E procedures, the experience in those States whose partial-birth abortion acts have been allowed to go into effect proves that physicians *do* understand the difference between what these statutes do and do not prohibit.

There is no statistical evidence that the enactment of partial-birth abortion statutes has "chilled" physicians from performing conventional first and second-trimester abortion procedures, including suction curettage and

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[18] The month of occurrence was not stated for four abortions.

dilation and evacuation, in those States whose laws are in force. Nor is there any evidence that these statutes have forced physicians to use instillation procedures instead of D & E's where instillation would have been contraindicated or compelled these physicians to send their patients out of State for abortions. In fact, the evidence, as set forth in this Brief, is to the contrary. And there is no evidence that physicians have modified their abortion procedures to the detriment of their pregnant women patients, as Dr. Christensen wrongly predicted in the challenge to the Wisconsin partial-birth abortion statute. Partial-birth abortion statutes were not intended to affect (and have not affected) conventional abortion procedures. That, in turn, suggests that plaintiff's expressed concerns about the vagueness and overbreadth of the statute are unfounded and served only to divert the attention of the courts below from the ultimate issue in this case, to wit, whether the D & X procedure may be prohibited. That is the issue this Court must reach and decide. For the reasons set forth in petitioners' brief, *amicus curiae* submits that Nebraska has enacted a constitutional statute to end the barbaric and unnecessary practice of partial-birth abortion.

CONCLUSION

For the foregoing reasons, as well as those set forth in petitioners' brief, the judgment of the court of appeals should be reversed.

Respectfully submitted,

PAUL BENJAMIN LINTON

Attorney at Law
921 Keystone Avenue
Northbrook, Illinois 60062
(847) 291-3848 (tel)
(847) 412-1594 (fax)

Counsel of Record
for the Amicus

February 28, 2000

APPENDIX A
INDIANA

[LOGO] Indiana State
Department of Health
An Equal Opportunity Employer

Frank L. O'Bannon
Governor

Richard D. Feldman, M.D.
State Health Commissioner

January 3, 2000

I, Robert Teclaw, State Epidemiologist for the State of Indiana, certify that the attached table, "Terminated Pregnancies by Month and Procedure, Indiana Occurrences, 1997", was obtained from this office.

These figures were obtained from the individual records "Indiana State Department of Health, Terminated Pregnancy Report", which are required by law to be filed with this agency by the physician performing the abortion.

/s/ Robert Teclaw
Robert Teclaw, DVM, MPH, Ph.D.
State Epidemiologist

STATE OF INDIANA)
) SS:
COUNTY OF Marion)

SUBSCRIBED AND SWORN TO before me, a Notary Public in and for the above state and county on this 4th day of January, 2000.

/s/ Robin R. Ellison
Robin R. Ellison
Notary Public

My Commission Expires:

April 21, 2007 [SEAL]

Terminated Pregnancies by Month and Procedure
Indiana Occurrences
1997

Month	Procedure						
	Suction Curettage	Sharp Curettage	Dilation and Evacuation	Intra-Uterine Prostaglandin	Other	Unknown	Total
January	1,149	10	13	1	8	44	**1,225**
February	1,084	10	9	0	5	42	**1,150**
March	1,079	7	16	1	4	14	**1,121**
April	1,132	5	4	0	7	21	**1,169**
May	1,142	9	10	0	8	27	**1,196**
June	1,011	9	20	0	19	30	**1,089**
July	1,026	8	24	0	7	70	**1,135**
August	976	4	18	0	19	75	**1,092**
September	983	5	7	0	31	4	**1,030**
October	1,026	7	20	0	16	18	**1,087**
November	918	7	11	0	21	23	**980**
December	903	6	7	0	15	3	**934**
Total	**12,429**	**87**	**159**	**2**	**160**	**371**	**13,208**

Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

[LOGO] Indiana State
Department of Health
An Equal Opportunity Employer

Frank L. O'Bannon
Governor

Richard D. Feldman, M.D.
State Health Commissioner

February 16, 2000

I, Robert Teclaw, State Epidemiologist for the State of Indiana, certify that the attached table, "Terminated Pregnancies by Procedure, Indiana Occurrences, 1998", was obtained from this office.

These figures were obtained from the individual records "Indiana State Department of Health, Terminated Pregnancy Report", which are required by law to be filed with this agency by the physician performing the abortion.

/s/ Robert Teclaw
Robert Teclaw, DVM, MPH, Ph.D.
State Epidemiologist

STATE OF INDIANA)
) SS:
COUNTY OF Marion)

SUBSCRIBED AND SWORN TO before me, a Notary Public in and for the above state and county on this 16th day of February, 2000.

/s/ Robin R. Ellison
Robin R. Ellison
Notary Public

My Commission Expires:
April 21, 2007 [SEAL]

Terminated pregnancies by Procedure
Indiana Occurrences, 1998

	Number	Percent
Suction Curettage	11,935	95.9
Sharp Curettage	64	0.5
Dilation & Evacuation	199	1.6
I-U Saline	0	0.0
I-U Prostaglandin	0	0.0
Hysterotomy	0	0.0
Other	113	0.9
Unknown	132	1.1
Total	12,443	100.0

Source:
Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

APPENDIX B
MISSISSIPPI

**[LOGO]MISSISSIPPI
STATE DEPARTMENT OF
HEALTH**

Bureau of Public Health Statistics
Post Office Box 1700 – 2423 North State Street
Jackson, Mississippi 39215-1700
601/576-7960

F.E. Thompson, Jr. MD, MPH
State Health Officer

December 28, 1999

Paul Benjamin Linton
Attorney at Law
921 Keystone Avenue
Northbrook, Illinois 60062

Dear Mr. Linton:

Enclosed as you requested is the table "Induced Terminations Performed in Mississippi in 1997, by Primary Procedure and Month Termination was Done," along with a notarized statement attesting to the origin of the figures.

Also enclosed is a copy of our **"Handbook on Registration and Reporting of Vital Events: Induced Terminations of Pregnancy."** In Appendix A on page 15 is a list of induced abortion procedures and their definitions. As far as I know, these are the only "official" definitions that exist.

Please feel free to write or call me at 601-576-7746 if you need anything further.

Sincerely,

/s/ Ann L. Leach
Ann L. Leach
Vital Statistics

Enclosures

[LOGO]MISSISSIPPI
STATE DEPARTMENT OF
HEALTH

Bureau of Public Health Statistics
Post Office Box 1700 – 2423 North State Street
Jackson, Mississippi 39215-1700
601/576-7960

F.E. Thompson, Jr. MD, MPH
State Health Officer

December 28, 1999

I, Ann L. Leach, Supervisor of the Vital Statistics Unit of the Mississippi State Department of Health, certify that the attached table, "Induced Terminations Performed in Mississippi in 1997, by Primary Procedure and Month Termination was Done," was obtained from this office.

These figures were obtained from the individual records "Report of Induced Termination of Pregnancy Performed in Mississippi," which are required by law to be filed with this office by the person in charge of any institution in Mississippi in which an induced termination of pregnancy is performed.

/s/ Ann L. Leach
Ann L. Leach, Supervisor
Vital Statistics Unit

STATE OF MISSISSIPPI)
)
COUNTY OF HINDS)

SUBSCRIBED AND SWORN TO before me, a Mississippi Statewide Notary Public on this 28th day of December, 1999.

/s/ Catrina Lache Davis
Catrina Lache Davis
Notary Public

My Commission Expires: Oct. 5, 2001

INDUCED TERMINATION PERFORMED IN MISSISSIPPI IN 1977
BY PRIMARY PROCEDURE AND MONTH PROCEDURE WAS DONE

	MONTH												
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
PROC	N	N	N	N	N	N	N	N	N	N	N	N	N
SUCTION CURRETTAGE	244	231	232	183	229	179	222	204	188	191	185	206	2494
SHARP CURRETTAGE	0	0	0	0	1	0	0	0	0	0	0	0	1
DILATION & EVACUATION	165	185	177	138	193	180	129	196	94	136	115	80	1788
INTRAUTERINE PROSTAGLANDIN INSTILLATION	0	2	3	0	3	0	2	0	2	5	2	4	23
OTHER	1	4	2	0	1	2	3	4	1	0	0	1	19
TOTAL	410	422	414	321	427	361	356	404	285	332	302	291	4325

APPENDIX C
SOUTH DAKOTA

[LOGO]

DEPARTMENT OF HEALTH
ADMINISTRATION
600 East Capitol Avenue
Pierre, South Dakota 57501-2536
605/773-3361 FAX: 605/773-5683

Paul Benjamin Linton
Attorney at Law
821 Keystone Avenue
Northbrook, IL 60062

RE: Table entitled "Induced Abortions Occurring in South Dakota by Month of Abortion and Type of Procedure, 1997".

State of South Dakota) Department
County of Hughes) of Health

I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on record in my office this 13 day of January, 2000.

/s/ Jerry C. Hofer, Director, Division of Administration

Subscribed and sworn to before me this 13 day of January, 2000.

/s/ Shirley J. Hartman
Notary Public: South Dakota

My commission expires: 8-11-2003

INDUCED ABORTIONS OCCURRING IN SOUTH DAKOTA BY MONTH OF ABORTION AND TYPE OF PROCEDURE, 1997

	Total	TYPE OF PROCEDURE	
		Suction Curettage	Dilation and Evacuation (D&E)
Total.....	919	702	217
MONTH OF ABORTION			
January.....	74	74	0
February.....	100	99	1
March.....	90	90	0
April.....	102	102	0
May.....	76	76	0
June.....	70	70	0
July.....	95	95	0
August.....	79	79	0
September.....	49	15	34
October.....	74	0	74
November.....	54	0	54
December.....	54	0	54
Not Stated.....	2	2	0

Source: South Dakota Department of Health

[LOGO]

DEPARTMENT OF HEALTH
ADMINISTRATION
600 East Capitol Avenue
Pierre, South Dakota 57501-2536
605/773-3361 FAX: 605/773-5683

Paul Benjamin Linton
Attorney at Law
821 Keystone Avenue
Northbrook, IL 60062

RE: Table entitled "Induced Abortions Occurring in South Dakota by Type of Procedure, 1996 and 1998".

State of South Dakota) Department
County of Hughes) of Health

I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on record in my office this 14th day of February, 2000.

/s/ Jerry C. Hofer
Jerry Hofer,
Director, Division of Administration

Subscribed and sworn to before me this 14 day of February, 2000.

/s/ Shirley J. Hartman
Notary Public: South Dakota

My commission expires: 8-11-2003

INDUCED ABORTIONS OCCURRING IN SOUTH DAKOTA BY PROCEDURE 1996

Total.....901
PROCEDURE TYPE
SUCTION
CURETTAGE.....595
DILATION &
EVACUATION 306

Source: South Dakota Department of Health

INDUCED ABORTIONS OCCURRING IN SOUTH DAKOTA BY PROCEDURE 1998

Total.....674
PROCEDURE TYPE
MEDICAL..... 1
DILATION &
EVACUATION 673

Source: South Dakota Department of Health

APPENDIX D
VIRGINIA

D-1

[SEAL]

COMMONWEALTH OF VIRGINIA

Department of Health

DEBORAH M. LITTLE
DIRECTOR AND STATE REGISTRAR

OFFICE OF VITAL
RECORDS AND HEALTH
STATISTICS
P.O. BOX 1000
RICHMOND, VA 23208-1000

January 19, 2000

Mr. Paul Linton
921 Keystone Avenue
Northbrook, Ill 60062

Dear Mr. Linton:

Enclosed please find the table of induced termination of pregnancy statistics you recently requested along with a "Declaration of Custodian of Public Record" document. The statistical table reflects those induced terminations of pregnancy events occurring within Virginia regardless of the place of residence of the individual. It provides the frequency of events cross tabulating month of occurrence by procedure terminating the pregnancy. This table reflects final numbers for calendar year 1998.

If there are any questions regarding the enclosed, please contact me by phone at 804-225-5075 or by email at *rhyman@vdh.stat.va.us*.

Sincerely,

/s/ Ronald S. Hyman

Ronald S. Hyman, Director
Virginia Center for Health Statistics
PO Box 1000
Richmond, VA 232218-1000

Enclosures (2)

DECLARATION OF CUSTODIAN OF PUBLIC RECORD, FEDERAL RULES OF EVIDENCE, RULE 803(8)

I, Ronald S. Hyman, Director, Division of Health Statistics, Office of Vital Records and Health Statistics, Virginia Department of Health, Commonwealth of Virginia, hereby certify that I am custodian of the records of the Division of Health Statistics, Office of Vital Records and Health Statistics, Virginia Department of Health, a public office of the Commonwealth of Virginia, not pertaining to a court, and I do certify that the document annexed to this certificate is a true and correct copy of an original, which is on file in my office located at Room 308, James Madison Building, 109 Governor Street, Richmond, Virginia, and that the original is a record kept in that office.

Dated, and the official seal of my office affixed, this 19th day of January 2000.

/s/ Ronald S. Hyman
Ronald S. Hyman
Director, Division of Health Statistics
Office of Vital Records
and Health Statistics
Virginia Department of Health
Commonwealth of Virginia

INDUCED TERMINATIONS OF PREGNANCY OCCURRING IN VIRGINIA BY MONTH OF OCCURRENCE BY PROCEDURE TERMINATING PREGNANCY, VIRGINIA 1998

Month of Occurrence	Total	Curettage		Dilation & Evacuation	IU Instillation		Hyster-otomy	Hyster-ectomy	Other	Unknown
		Suction	Sharp		Saline	Prostaglandin				
January	2,488	2,395	1	25	2	6			51	8
February	2,083	1,992		23		5			61	2
March	2,238	2,128	3	22		12			63	10
April	2,138	2,062		26		5			40	5
May	2,176	2,082	2	26	1	13			50	2
June	2,218	2,120	3	22	3	7			55	8
Sub-total	13,341	12,779	9	144	6	48	0	0	320	35
July	2,202	2,096	1	22		6	1		73	3
August	2,112	2,021	2	14	1	5	1	1	59	8
September	1,984	1,867	1	25	1	10		1	76	3
October	2,355	2,249	1	15	2	11			70	7
November	2,005	1,905		22		11			55	12
December	2,115	2,002		26	1	7	1		70	8
Sub-total	12,773	12,140	5	124	5	50	3	2	403	41
Unknown	1	1								
TOTAL	26,115	24,920	14	268	11	98	3	2	723	76

[SEAL]

COMMONWEALTH OF VIRGINIA

Department of Health

DEBORAH M. LITTLE
DIRECTOR AND
STATE REGISTRAR

OFFICE OF VITAL
RECORDS AND HEALTH
STATISTICS
P.O. BOX 1000
RICHMOND, VA 23208-1000

February 15, 2000

Mr. Paul Linton
921 Keystone Avenue
Northbrook, Ill 60062

Dear Mr. Linton:

Enclosed please find the table of induced termination of pregnancy statistics you recently requested along with a "Declaration of Custodian of Public Record" document. The statistical table reflects those induced terminations of pregnancy events occurring within Virginia regardless of the place of residence of the individual. It provides the frequency of events cross tabulating month of occurrence by procedure terminating the pregnancy. This table reflects final numbers for calendar year 1997.

If there are any questions regarding the enclosed, please contact me by phone at 804-225-5075 or by email at *rhyman@vdh.stat.va.us*.

Sincerely,

/s/ Ronald S. Hyman
Ronald S. Hyman, Director
Virginia Center for Health Statistics
PO Box 1000
Richmond, VA 232218-1000

Enclosures (2)

DECLARATION OF CUSTODIAN OF PUBLIC RECORD, FEDERAL RULES OF EVIDENCE, RULE 803(8)

I, Ronald S. Hyman, Director, Division of Health Statistics, Office of Vital Records and Health Statistics, Virginia Department of Health, Commonwealth of Virginia, hereby certify that I am custodian of the records of the Division of Health Statistics, Office of Vital Records and Health Statistics, Virginia Department of Health, a public office of the Commonwealth of Virginia, not pertaining to a court, and I do certify that the document annexed to this certificate is a true and correct copy of an original, which is on file in my office located at Room 308, James Madison Building, 109 Governor Street, Richmond, Virginia, and that the original is a record kept in that office.

Dated, and the official seal of my office affixed, this 15th day of February 2000.

/s/ Ronald S. Hyman
Ronald S. Hyman
Director, Division of Health Statistics
Office of Vital Records
and Health Statistics
Virginia Department of Health
Commonwealth of Virginia

Month of Event by Termination Procedure Reported
Induced Terminations of Pregnancy, Virginia, 1997

Month of Occurrence	Curettage		Dilation & Evacuation	IU Instillation		Hysterotomy	Hysterectomy	Other	Unknown	Total
	Suction	Sharp		Saline	Prostaglandin					
January	2,449	11	9	2	9		1	5	3	2,489
February	2,294	1	16	2	8	1	1	7	4	2,334
March	2,418		16		4			11	5	2,454
April	2,156	3	25		4			7	3	2,198
May	2,360	2	11	1	10			8	10	2,402
June	2,035	2	22		7	1		6	9	2,082
Subtotal	13,712	19	99	5	42	2	2	44	34	13,959
July	2,308	2	13		3			2	6	2,334
August	2,184		23		4			8	4	2,223
September	1,794		18		7			14	2	1,835
October	1,992	1	24		7			5	4	2,033
November	1,803	3	20	2	5			19	3	1,855
December	1,767	4	23		2			43	11	1,850
Subtotal	11,848	10	121	2	28	-	-	91	30	12,130
Total	25,560	29	220	7	70	2	2	135	64	26,089

APPENDIX E
SOUTH CAROLINA

D H E C
[LOGO]

2600 Bull Street
Columbia, SC 29201-1708

COMMISSIONER:
Douglas E. Bryant

BOARD:
Bradford W. Wyche
Chairman
William M. Hull, Jr., MD
Vice Chairman
Mark B. Kent
Secretary

Howard L. Brilliant, MD

Brian K. Smith

Rodney L. Grandy

Larry R. Chewning, Jr. DMD

February 10, 2000

Paul Linton, Attorney at Law
921 Keystone Avenue
Northbrook, IL 60062

Dear Attorney Linton:

As per your telephone request, enclosed is a table with a certified statement showing abortions occurring in South Carolina by type of procedure for 1996 and 1998. Also abortions by type of procedure by month of occurrence for 1997.

If you have any questions or if we can provide additional assistance, please let us know.

Sincerely,

/s/ Mary Hill Glover

Mary Hill Glover
Statistical and Research Analyst
Division of Biostatistics
Office of Public Health Statistics
and Information Systems.

Enclosure (1)

SPE0207.001/ABORTION

Abortions by Type of Procedure
South Carolina, 1996 & 1998
(Occurrence Data)

Type of Procedure	1996	1998
South Carolina	**9,326**	**8,801**
Suction Curettage	9,231	8,769
Sharp Curettage	16	2
D & E	14	-
Prostaglandin Instill	28	10
Hysterectomy	1	1
Other	29	15
Unknown	7	4

Abortions by Type of Procedure by Month
South Carolina, 1997
(Occurrence Data)

Type of Procedure	South Carolina	January	February	March	April	May	June
Suction Curettage	9,158	840	813	874	826	834	727
D & E	2	-	-	-	1	-	-
Saline	1	-	-	-	-	-	1
Prostaglandin Instill	20	4	1	1	2	1	3
Other	26	3	2	3	1	-	1
Unknown	5	1	-	-	1	-	1
Total	9,212	848	816	878	831	835	733

Type of Procedure	July	August	September	October	November	December
Suction Curettage	808	803	687	676	630	640
D & E	-	-	-	-	1	-
Saline	-	-	-	-	-	-
Prostaglandin Instill	2	1	1	1	3	-
Other	3	2	1	3	4	3
Unknown	-	1	-	-	-	1
Total	813	807	689	680	638	644

Prepared by:
Division of Biostatistics
Office of Public Health Statistics and Information Systems
South Carolina Department of Health and Environmental Control
Columbia, SC 29201

ATTEST: These data were tabulated from official Induced Termination of Pregnancy reports (abortions) filed with the South Carolina Department of Health and Environmental Control.

DATE: February 10, 2000

Murray B. Hudson, M.P.H.
Director of Public Health Statistics
& Information Systems

APPENDIX F
TENNESSEE

[SEAL]

TENNESSEE DEPARTMENT OF HEALTH
Health Statistics and Research
Cordell Hull Building, 4th Floor
425 5th Avenue North
Nashville, TN 37247-5262

January 25, 2000

Mr. Paul Benjamin Linton
Attorney at Law
921 Keystone Avenue
Northbrook, Illinois

Dear Mr. Linton:

Please find enclosed the statistical table on Tennessee resident abortion data for calendar year 1997, which you requested. This table was prepared from an electronic data file compiled from records and reports filed with the Tennessee Department of Health pursuant to Tennessee Code Annotated 39-15-203. This table has been reviewed and checked, and to the best of our knowledge reflect an accurate portrayal of the summary information requested as reported to the Tennessee Department of Health.

We hope that the information that we were able to provide you is helpful, and should you need any other information which is not confidential please let us know. Thank you for your interest and concern.

Sincerely,

/s/ Tom Spillman

Thomas Spillman
Chief, Statistical Services

[SEAL]

TENNESSEE DEPARTMENT OF HEALTH
Health Statistics and Research
Cordell Hull Building, 4th Floor
425 5th Avenue North
Nashville, TN 37247-5262

I, Thomas Spillman, Chief of Statistical Services, Tennessee Department of Health, certify that the attached table "1997 Recorded Abortions in Tennessee, Table by Month by Procedure" was obtained from this office.

This table was prepared from an electronic data file compiled from records and reports required to be filed with the Tennessee Department of Health pursuant to Tennessee Code Annotated 39-15-203. This table has been reviewed and checked, and to the best of my knowledge reflect an accurate portrayal of information reported to the Tennessee Department of Health.

/s/ Thomas Spillman

Thomas Spillman
Chief, Statistical Services

STATE OF TENNESSEE)
) SS:
COUNTY OF Davidson)

SUBSCRIBED AND SWORN TO before me, a Notary Public for Davidson County, on this 25 day of January, 2000.

Signed: /s/ Alice Faye Dickson
Printed:
Notary Public

My Commission Expires:
3-23-2000

1997 RECORDED ABORTIONS IN TENNESSEE
MONTH OF OCCURRENCE BY PRIMARY PROCEDURE

10:57 FRIDAY, JANUARY 21, 2000

THE FREQ PROCEDURE

TABLE OF MONTH BY TYPEX

MONTH / TYPEX FREQUENCY	SUCTION CURETTAGE	DILATION & EVACUAT	INTRA-UT SALINE	INTRA-UT PROST	HYSTER-ECTOMY	UNKNOWN	TOTAL
JANUARY	1650	0	0	5	0	0	1655
FEBRUARY	1658	0	0	5	0	0	1663
MARCH	1610	2	0	2	1	0	1615
APRIL	1453	0	0	5	0	0	1458
MAY	1571	0	0	7	0	0	1578
JUNE	1447	2	0	2	0	0	1451
JULY	1607	0	0	3	0	0	1610
AUGUST	1575	0	0	4	0	1	1580
SEPTEMBER	1446	2	0	3	0	0	1451
OCTOBER	1442	0	1	7	0	0	1450
NOVEMBER	1351	0	0	9	0	2	1362
DECEMBER	1398	1	0	4	0	3	1406
UNKNOWN	4	0	0	0	0	0	4
TOTAL	18212	7	1	56	1	6	18283

[SEAL]

TENNESSEE DEPARTMENT OF HEALTH
Health Statistics and Research
Cordell Hull Building, 4th Floor
425 5th Avenue North
Nashville, TN 37247-5262

February 11, 2000

Mr. Paul Benjamin Linton
Attorney at Law
921 Keystone Avenue
Northbrook, Illinois

Dear Mr. Linton:

Please find enclosed the statistical table on abortions occurring in Tennessee for calendar year 1996 and 1998, which you requested. These tables were prepared from an electronic data file compiled from records and reports filed with the Tennessee Department of Health pursuant to Tennessee Code Annotated 39-15-203. These tables have been reviewed and checked, and to the best of our knowledge reflect an accurate portrayal of the summary information requested as reported to the Tennessee Department of Health.

We hope that the information that we were able to provide you is helpful, and should you need any other information which is not confidential please let us know. Thank you for your interest and concern.

Sincerely,

/s/ Thomas Spillman

Thomas Spillman
Chief, Statistical Services

[SEAL]

TENNESSEE DEPARTMENT OF HEALTH
Health Statistics and Research
Cordell Hull Building, 4th Floor
425 5th Avenue North
Nashville, TN 37247-5262

I, Thomas Spillman, Chief of Statistical Services, Tennessee Department of Health, certify that the attached tables "1996 Recorded Abortions in Tennessee, Table by Month by Procedure" and "1998 Recorded Abortions in Tennessee, Table by Month by Procedure" were obtained from this office.

These tables was prepared from an electronic data file compiled from records and reports required to be filed with the Tennessee Department of Health pursuant to Tennessee Code Annotated 39-15-203. These tables have been reviewed and checked, and to the best of my knowledge reflect an accurate portrayal of information reported to the Tennessee Department of Health.

/s/ Tom Spillman

Thomas Spillman
Chief, Statistical Services

STATE OF TENNESSEE)
) SS:
COUNTY OF Davidson)

SUBSCRIBED AND SWORN TO before me, a Notary Public for Davidson County, on this 11 day of February, 2000.

Signed: /s/ Alice Faye Dickson
Printed: Alice Faye Dickson
Notary Public

My Commission Expires:
March 23, 2000

1996 RECORDED ABORTIONS IN TENNESSEE
MONTH OF OCCURRENCE BY PRIMARY PROCEDURE

14:12 TUESDAY, FEBRUARY 8, 2000

THE FREQ PROCEDURE

TABLE OF MONTH BY TYPEX

MONTH / TYPEX / FREQUENCY	SUCTION CURETTAGE	SHARP CURETTAGE	DILATION & EVACUAT	INTRA-UT SALINE	INTRA-UT PROST	HYSTER-ECTOMY	UNKNOWN	TOTAL
JANUARY	1584	1	0	0	4	1	1	1591
FEBRUARY	1504	0	0	0	9	0	3	1516
MARCH	1768	0	0	0	3	0	3	1774
APRIL	1514	2	1	0	5	0	2	1524
MAY	1511	1	1	0	6	0	0	1519
JUNE	1530	1	0	1	3	0	0	1535
JULY	1424	0	0	0	5	0	1	1430
AUGUST	1560	0	1	0	6	0	2	1569
SEPTEMBER	1339	0	0	0	2	0	0	1341
OCTOBER	1450	1	0	0	7	0	0	1458
NOVEMBER	1408	0	1	0	7	0	0	1416
DECEMBER	1307	0	0	0	4	0	0	1311
UNKNOWN	4	0	0	0	1	0	0	5
TOTAL	17903	6	4	1	62	1	12	17989

SOURCE: HEALTH STATISTICS AND RESEARCH, TDH (N136)

1998 RECORDED ABORTIONS IN TENNESSEE
MONTH OF OCCURRENCE BY PRIMARY PROCEDURE

14:12 TUESDAY, FEBRUARY 8, 2000

THE FREQ PROCEDURE

TABLE OF MONTH BY TYPEX

MONTH / FREQUENCY	TYPEX OTHER	SUCTION CURETTAGE	DILATION & EVACUAT	INTRA-UT SALINE	INTRA-UT PROST	HYSTER-OTOMY	HYSTER-ECTOMY	UNKNOWN	TOTAL
JANUARY	0	1696	6	0	1	0	0	14	1717
FEBRUARY	0	1612	14	0	3	0	0	9	1638
MARCH	0	1584	6	0	12	0	0	39	1641
APRIL	1	1421	2	0	1	0	0	6	1431
MAY	1	1442	6	0	2	0	0	23	1474
JUNE	0	1513	5	0	5	0	1	6	1530
JULY	1	1344	16	1	3	1	1	3	1370
AUGUST	1	1428	9	2	7	0	0	10	1457
SEPTEMBER	0	1312	1	0	1	0	0	9	1323
OCTOBER	0	1342	0	0	2	0	0	4	1348
NOVEMBER	0	1106	0	0	5	0	0	34	1145
DECEMBER	2	1200	0	0	4	0	0	29	1235
UNKNOWN	0	89	1	0	0	0	0	4	94
TOTAL	6	17089	66	3	46	1	2	190	17403

SOURCE: HEALTH STATISTICS AND RESEARCH, TDH (N136)

Feb 28 2007

(19)

Supreme Court, U.S.
FILED
FEB 28 2007
CLERK

No. 99-830

IN THE

Supreme Court of the United States

DON STENBERG, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF THE AMERICAN CENTER FOR LAW & JUSTICE AND THE THOMAS MORE CENTER FOR LAW & JUSTICE AS AMICI SUPPORTING PETITIONERS

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28pp

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*. This brief is filed with consent of the parties–letters indicating that consent are being filed with the brief.

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No. 99-830
In the
Supreme Court of the United States

Don Stenberg, et al.,

Petitioners,

v.

Leroy Carhart, M.D.,

Respondent.

Statement of Interest of Amici*

The American Center for Law & Justice

The American Center for Law and Justice ("ACLJ") is a national, non-profit, public interest law firm. The ACLJ is devoted to safeguarding the sanctity of human life. The ACLJ accomplishes that goal through education, litigation, legislative assistance, and related activities.

ACLJ attorneys have advocated in defense of human life in state and federal courts and have appeared in numerous cases before this Court. The ACLJ's Chief Counsel has argued several cases before this Court, including *Lamb's Chapel v. Center Moriches Union Free School District*, 508 U.S. 384 (1993), *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263 (1993), *Schenck v. Pro-Choice Network of Western New York, Inc.*, 519 U.S. 357 (1997), and *Hill v. State of Colorado*,

---

* No counsel of a party authored this brief in whole or in part, and no person or entity, other than the *amicus curiae*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

No. 98-1856 (argued Jan. 19, 2000).[1]

The ACLJ files this brief in support of the Petitioners. The ACLJ seeks to bring to this Court's attention its view that the decision below represents a transformation of the abortion liberty announced in *Roe v. Wade*, 410 U.S. 113 (1973), and substantially reaffirmed in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). Neither *Roe* nor *Casey* recognized a liberty interest in, or a constitutional right to, the death of an unwanted or unplanned child. Moreover, the ACLJ seeks to bring to this Court's attention its view that this Court's "abortion jurisprudence," which the Court has most recently defended as a thing deemed socially necessary rather than necessarily legally correct, *Casey*, 505 U.S. at 854-69

1. In addition, ACLJ attorneys have filed briefs for amici curiae or parties in numerous other matters in this Court, including *Mitchell v. Helms*, No. 98-1648 (argued Dec. 1, 1999); *Board of Regents of University of Wisconsin System v. Southworth*, No. 98-1189 (argued Nov. 9, 1999); *National Endowment for the Arts v. Finley*, 524 U.S. 569 (1998); *Reno v. American Civil Liberties Union*, 521 U.S. 844 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997); *City of Boerne v. Flores*, 521 U.S. 507 (1997); *Denver Area Educational Telecommunications Consortium, Inc. v. F.C.C.*, 518 U.S. 727 (1996); *Romer v. Evans*, 517 U.S. 620 (1996); *Rosenberger v. Rector and Visitors of University of Virginia*, 515 U.S. 819 (1995); *Capitol Square Review and Advisory Bd. v. Pinette*, 515 U.S. 753 (1995); *Board of Educ. of Kiryas Joel Village School Dist. v. Grumet*, 512 U.S. 687 (1994); *National Organization for Women v. Scheidler*, 510 U.S. 249 (1994); *Zobrest v. Catalina Foothills School Dist.*, 509 U.S. 1 (1993); *International Soc. for Krishna Consciousness, Inc. v. Lee*, 505 U.S. 672 (1992); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992); *Lee v. Weisman*, 505 U.S. 577 (1992).

(relying on *stare decisis* as justification for sustaining "central holding" of *Roe*), has not, to this point, addressed whether the deliberate and willful violence that marks the practice defended by abortionist Leroy Carhart even constitutes an "abortion" as this Court has used that term.

The Thomas More Center for Law & Justice

The Thomas More Center for Law & Justice is a national, not-for-profit, public interest law firm based in Ann Arbor, Michigan. The Thomas More Center is dedicated to educating and defending the citizens of the United States with respect to their constitutional rights and liberties, particularly, in defending the sanctity of human life. The Thomas More Center accomplishes these goals through education, litigation, legislative assistance, and related activities.

Summary of Argument

In the present case, Leroy Carhart, an abortionist who commits "partial birth" abortions, brought a facial challenge to a Nebraska statute banning such abortions. Nebraska has defended its statute under this Court's precedents. In error, the court below concluded that Nebraska's statute is facially unconstitutional. In doing so, the court expressed the view that this Court had changed the standard normally applicable to facial challenges – the "no set of circumstances" test, *see United States v. Salerno*, 481 U.S. 739, 745 (1987) ("[a] facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid."). Consequently, the court below applied

the so-called "large fraction" test employed by the joint opinion in *Casey*, 505 U.S. at 895 ("[t]he unfortunate yet persisting conditions we document above will mean that in a large fraction of the cases in which § 3209 is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion").

The decision below is due to be reversed. The court below erred both by applying the "large fraction" test *instead* of the "no set of circumstances" test and by concluding that the Nebraska statute failed the "large fraction" test. First, nothing in *Casey* directs the courts to disregard *Salerno* and the test it identifies for facial challenges. In two prior decisions, this Court applied *Salerno* to determine whether facial challenges to abortion regulations were facially constitutional. *See Webster v. Reproductive Health Servs.*, 492 U.S. 490 (1989); *Ohio v. Akron Ctr. for Reproductive Health*, 497 U.S. 502 (1990). Second, under a proper reading of Nebraska's statute – the reading given to the statute by its law enforcement officials – Nebraska's statute passes the "large fraction" test.

The judgment below is due to be reversed even without reaching the question of whether this Court should overrule *Roe v. Wade*. In the view of these amici, however, no argument in defense of state restrictions on abortion can be soundly made if it omits the fundamental principle: this Court erred in *Roe*, when it held that babies still inside their mothers' wombs are not "persons" with rights under the Constitution. The Court compounded that error with the conclusion that the right of a mother to abort her pregnancy was guaranteed by the Fourteenth Amendment. This Court should candidly admit the errors it committed in peeling away from children before birth

the protective mantle of rights afforded to others by the United States Constitution. This Court should overrule *Roe*.

ARGUMENT

I. THE NEBRASKA "PARTIAL-BIRTH" ABORTION STATUTE PROHIBITS ONLY THE SO-CALLED INTACT D & X PROCEDURE TO CAUSE THE DEATH OF A CHILD DURING THE PROCESS OF DELIVERY, A TECHNIQUE THAT FINDS NO COVER IN EITHER *ROE* OR *CASEY*

A. The Nebraska Statute

The Nebraska statute, as construed by the law enforcement officers of that State, restricts only the so-called Intact Dilation and Extraction ("D & X") procedure. That procedure, which consists of an induced partial delivery of the child, would not even be considered by the *Roe* Court to constitute an abortion. *See* Brief Amici Curiae of Louisiana, *et al.* (citing transcript of reargument in *Roe*). Instead, such a procedure is a form of parturitional infanticide that was not legitimized by *Roe*.

Nebraska's Legislative Bill 23 (hereafter "LB 23"), a bill enacted by the Nebraska Legislature prohibiting "partial-birth abortion" was signed into law in 1997. LB 23 provides:

> No partial-birth abortion shall be performed in this state, unless such procedure is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from

the pregnancy itself.

Neb.Rev.Stat. § 28-328(1) (1998). The term "partial-birth abortion" is defined as:

> an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. For purposes of this subdivision, the term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.

Neb.Rev.Stat. § 28-326(9) (1998). Commission of a prohibited "partial-birth abortion" constitutes a Class III felony. See Neb.Rev.Stat. § 28-328(2) (1998). An abortionist who intentionally and knowingly performs an unlawful "partial-birth abortion" will automatically have his license to practice medicine in Nebraska suspended and revoked. See Neb.Rev.Stat. § 28-328(4) (1998).

B. Neither *Roe* Nor *Casey* Recognize a Right of a Mother to Insist That Her Unborn Child Be Substantially Delivered out of Her Uterus and Then Killed by the Evacuation of the Contents of the Child's Skull.

The court below breezily concluded that *Roe* and *Casey* mandate the result it reached. That conclusion ascribes to the

majorities in those cases a quite specific intent about the meaning of the right to an abortion in later pregnancy. Nothing in those decisions, however, lends support to the court below.

By statute, the Nebraska Legislature has prohibited one particularly gruesome form of near birth infanticide. The abortion right announced in *Roe v. Wade*, and retained as a liberty interest in *Casey*, however, has little to do with the present facial challenge to a statutory ban on D & X infanticide. In *Roe*, this Court held that the Texas anti-abortion statutes at issue were unconstitutional. 410 U.S. at 164-66. The *Roe* Court also noted that another Texas statute that bans killing a child in the process of being born was unchallenged and unaffected. 410 U.S. at 117 n.1.[2] Nothing in the joint opinion in *Casey* or in any of the concurrences lends no support to Respondent's challenge because nothing in that decision expanded the abortion liberty to include destruction of a partially born child.

Popular nomenclature aside, D & X procedures are not true abortions. When the physician delivers the lethal blow in a partial birth abortion, the child "is merely inches from being delivered and obtaining full legal rights of personhood under the U.S. Constitution." *Planned Parenthood of Wisconsin v.*

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2. The Texas statute read: "[W]hoever shall during parturition of the mother destroy the vitality or life in a child in a state of being born and before actual birth, which child would otherwise have been born alive, shall be confined in the penitentiary for life or for not less than five years." Texas Penal Code Art. 1195 (1973). "Parturition" is the action or process of giving birth to offspring. WEBSTER'S COLLEGIATE DICTIONARY 848 (10th ed. 1995).

Doyle, 44 F. Supp. 2d 975, 982 (W.D. Wis. 1999) (citations omitted), *aff'd in part on other grounds, rev'd in part on other ground, sub nom., Hope Clinic v. Ryan*, 193 F.3d 857 (7th Cir. 1999) (en banc) (upholding Illinois and Wisconsin partial birth abortion bans). Such a procedure, amidst parturition, is "closer to infanticide than it is to abortion." 44 F. Supp. at 982. The abortion liberty does not include an independent right to assure fetal death. Nor does the abortion liberty justify killing a child as he proceeds out of his mother's body.

The Eighth Circuit asserted two fundamentally flawed reasons for rejecting Nebraska's argument that its statute does not implicate the abortion liberty. *See* Pet. App. at 16-18. First, the trial court had concluded that LB 23 violated the abortion liberty as an undue burden on it because the statute restricted not only the intact D & X abortion technique, but also the Dilatation and Extraction (hereafter, "D & E") technique. Pet. App. at 16. Nebraska countered that the statute only applied to the D & X technique. The Eighth Circuit affirmed the trial court's decision to ignore Nebraska's construction of its statute and considered abortionist Carhart's challenge to the statute as one challenging a restriction on *both* intact D & X infanticide and D & E abortions. Pet. App. at 18.

Second, the Eighth Circuit appears to take the mistaken position that *Roe* and *Casey* foreclose Nebraska's arguments. The court below specifically eschewed decision of the question whether "there is a separate legal category for the "partially born," Pet. App. at 20. Although the court below paled in the face of that question, it affirmed the judgment that the statute was facially unconstitutional; in doing so, it effectively precluded that category of human beings from holding any legal

significance.

The distinction drawn by the joint opinion in *Casey* between viable and non-viable fetuses has relevance — so long as the context is "abortion." That distinction does not define the boundaries of what constitutes "abortion" for purposes of constitutional law. Whether "abortion" is so expansive a concept that it includes death to a child being born is a point that *Casey* — like *Roe* — did not reach.

The destruction of a living human child in utero with the mother's consent is an abortion. Until this Court corrects its own error, or the Constitution is amended to correct that error, or the turmoil exacerbated by this Court's intrusion into the issue makes continued abortion on demand untenable, state regulation of such conduct must be judged by existing abortion jurisprudence. Presumably, abortionist Carhart would agree that it is homicide of an infant if a child is killed after being fully born and that such an act is not an abortion. That conclusion even obtains where the nonviability of the newly born child would impair the child's ability to survive.

When a child is between the womb and the outside world and in transition, he has an "in between" status that this Court has not addressed. Under our federal system, the lack of any precedent one way or the other is an argument in support of Nebraska's authority, not against it. Nebraska's authority to adopt the challenged statute is plenary.

II. RESPONDENT'S FACIAL CHALLENGE TO NEBRASKA'S STATUTORY BAN ON ONE FORM OF PERINATAL INFANTICIDE IS SUBJECT TO, AND FAILS, THE SALERNO STANDARD.

The Eighth Circuit erroneously concluded that the Respondent succeeded in his facial challenge. Its error, in the first instance, resulted from its choice of the wrong standard by which to judge a facial challenge to the constitutionality of the Act. It should have used the "no set of circumstances" test from *Salerno*, 481 U.S. at 745. Instead, it erroneously construed *Casey* to have displaced the *Salerno* standard with a new "large fraction" test, *see Casey*, 505 U.S. at 895. Nebraska prevails under either test; because application of *Salerno* leads to that victory directly, it warrants careful consideration.

In ordinary litigation, a party who brings a facial challenge against a statute faces the Herculean task. To succeed, such a challenger must demonstrate that there is "no set of circumstances" in which the statute operates constitutionally. *Salerno*, 481 U.S. at 745. The exception to that general rule is found in the discrete category of facial challenges that assert that a statute trenches unconstitutionally on rights guaranteed by the Free Speech Clause of the First Amendment. *See, e.g., Forsyth County v. Nationalist Movement*, 505 U.S. 123, 129-30 (1992) (citing additional cases).

In *Salerno*, this Court said that, in a "facial challenge" to a statute, "the challenger must establish that no set of circumstances exist under which the Act would be valid." 481 U.S. at 745. After deciding *Salerno*, this Court followed the rule explained in *Salerno* in two subsequent facial challenges

to abortion laws, *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 524 (1989) (O'Connor, J., concurring in part and concurring in the judgment) (citing *Salerno*); *Ohio v. Akron Ctr. for Reproductive Health*, 497 U.S. 502, 514 (1990) (citing *Salerno* and O'Connor concurrence in *Webster*).

In *Webster*, this Court considered facial challenges to several statutory restrictions imposed by Missouri on the use of its own public resources. By statute, Missouri restricted the use of public employees and facilities for the performance or assistance of elective abortions. 492 U.S. at 507-12. In *Webster*, this Court concluded that such restrictions do not contravene its abortion decisions. *Id.* That conclusion arose from the rudimentary principle that the Due Process Clauses do not grant any affirmative right to governmental assistance, even where such assistance is needed to secure life, liberty, or property interests of which the government may not deprive the individual. *See DeShaney v. Winnebago County Dept. of Social Services*, 489 U.S. 189, 196 (1989).

The *Webster* plurality noted that, in a series of cases – *Maher v. Roe*, 432 U.S. 464 (1977); *Poelker v. Doe*, 432 U.S. 519 (1977); *Harris v. McRae*, 448 U.S. 297 (1980) – this Court affirmed the constitutionality of regulations denying public funds for elective abortions while, at the same time, allowing payments for medical services related to childbirth; that line of cases embodied this Court's recognition that a government's decision to favor childbirth over abortion through its particular allocation of public resources does not violate *Roe*. From that line of cases, the *Webster* plurality reasoned that a State could implement that value judgment by its allocation of other public resources, such as hospitals and medical staff. Just as in

Maher, *Poelker*, and *Harris*, this Court concluded in *Webster* that Missouri's decision to use public facilities and employees to encourage childbirth over abortion did not place any governmental obstacle between a woman who chooses to abort her unborn child.

Justice O'Connor concurred in part and concurred in the judgment in *Webster*. 492 U.S. at 522. In that concurrence, Justice O'Connor concluded that the challenges to the statutory restrictions on the use of state employees and facilities must fail because "some quite straightforward applications of the Missouri ban on the use of public facilities for performing abortions would be constitutional and that is enought to defeat" the facial challenge. That conclusion is the narrowest ground of concurrence stated by the judges whose votes decided *Webster*. Following this Court's teaching that, in cases where no opinion commands a majority, the concurrence stating the narrowest ground of decision represents the holding of the Court,[3] it is reasonable to conclude that Justice O'Connor's opinion – which applied *Salerno* to dismiss the facial challenges – was the *Webster* Court's holding in that respect.

Any lingering uncertainty, however, about the foregoing conclusion was resolved in *Ohio v. Akron Ctr. for Reproductive Health*, 497 U.S. 502 (1990). There, the Court considered an

3. "When a fragmented Court decides a case and no single rationale explaining the result enjoys the assent of five Justices, 'the holding of the Court may be viewed as that position taken by those Members who concurred in the judgments on the narrowest grounds . . . .'" *Marks v. United States*, 430 U.S. 188, 193 (1977) (citation omitted).

Ohio statute limiting access to abortion by requiring that notice be given to the parents of an unmarried, unemancipated, minor woman unless a court order approving the abortion was obtained. *Id.* at 506. In its decision, the Court specifically relied on *Salerno* and invoked Justice O'Connor's concurrence in turning away a facial challenge to the statute. *Id.* at 414.

The Eighth Circuit erred in treating *Casey*'s "large fraction" as displacing *Salerno*'s "no set of circumstances" test.[4] A

4. The courts of appeals are divided on whether *Casey* displaced *Salerno* in abortion jurisprudence with a more lenient "large fraction" standard. Four circuits — the Sixth, Eighth, Ninth and Tenth — read *Casey* to have abandoned *Salerno*. *See Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187, 193-96 (6th Cir. 1997); *Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1456-58 (8th Cir. 1995); *Planned Parenthood of Southern Ariz v. Lawall*, 180 F.3d 1022 (9th Cir. 1999); *Jane L. v. Bangerter*, 102 F.3d 1112, 1116 (10th Cir. 1996). The Fifth Circuit disagrees and adheres to *Salerno*. *See Barnes v. Moore*, 970 F.2d 12, 14 n.2 (5th Cir. 1992). Accord *Causeway Med. Suite v. Ieyoub*, 109 F.3d 1096, 1103-04 (5th Cir. 1997) (noting the practice of the Fifth Circuit to await decisions of this Court actually effecting a change in law, rather than prognosticating about future changes in law based on dicta in opinions dissenting from, or concurring in, the denial of certiorari). The Fourth Circuit has not decided a case in which choice between *Salerno* and *Casey* was required, but has stated, in dicta, its intention to apply the *Salerno* standard until this Court specifically directs otherwise:

> It is not the province of the court of appeals to predict how the Supreme Court will ultimately rule on an issue. *Casey* does not specifically overrule *Salerno*. At the moment, the most that can be said is that three Justices have indicated a desire to do so. Until the Supreme Court specifically does so, though, this Court

(continued...)

careful reading of *Casey* shows it does not displace *Salerno*. At issue in *Casey* was a Pennsylvania law requiring a woman to notify her husband before having an abortion. Recognizing that most married women would notify their husbands without being legally required to do so and that the law contained various exceptions, Pennsylvania argued that the notification requirement "impose[d] almost no burden at all for the vast majority of women seeking abortions" and that "the effects of [the requirement] are felt by only one percent of the women who obtain abortions." 505 U.S. at 894. Rejecting this argument, the *Casey* plurality said "[t]he proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Id.* A law, it said, must be "judged by reference to those for whom it is an actual ... restriction." *Id.* at 895. While this approach is different from the one urged by Pennsylvania, it does not

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4. (...continued)
is bound to apply the *Salerno* standard as it has been repeatedly applied in the context of other abortion regulations reviewed by the Supreme Court.

Manning v. Hunt, 119 F.3d 254, 268 n.4.

While three Justices of this Court have expressed their desire to overrule *Salerno*, three other Justices have expressed their support for the *Salerno* standard. *See Janklow v. Planned Parenthood, Sioux Falls Clinic*, 517 U.S. 1174, 1175-76 (1996) (Stevens, J. concurring in denial of certiorari); *Fargo Women's Health Organization v. Schafer*, 507 U.S. 1013, 1014 (1993) (O'Connor, J., and Souter, J., concurring in denial of stay pending appeal). *But see Janklow*, 517 U.S. at 1176-81 (1996) (Scalia, J., joined by Rehnquist, C.J., and Thomas, J., dissenting from denial of certiorari).

mandate the use of a "large fraction" test. Instead, at most, it means that the joint opinion offered a refinement of what counts as a "circumstance" when considering whether it has been shown that a statute is constitutional in "no set of circumstances."

The conclusion that *Salerno* still governs is strengthened by reviewing the concerns at work in *Casey*. Although the joint opinion expressed concern over the risk of spousal abuse, 505 U.S. at 888-893, a more basic concern was expressed. Specifically, the joint opinion reasoned that to subject any woman to a spousal notification requirement would invade her liberty in a way that equated her with a child. *Id.* at 898. Thus, whenever the requirement operates as a restriction (i.e., when a woman notifies her husband only because the law forces her), it is unconstitutional. If there are no circumstances where a law is constitutional, then it is invalid under *Salerno*.[5] No new standard was needed by the joint opinion in *Casey*. The hint of one at all is too faint and uncertain to be the basis for disregarding this Court's direct holding in *Salerno*, *Webster* and *Akron*.

With *Salerno* as the standard, Nebraska readily prevails. There are applications of the Act that Respondent cannot show are unconstitutional (e.g., as applied to post-viability elective

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5. While the dissenting Justices relied on the *Salerno* standard, their real point of disagreement was whether it is constitutional to require a woman to notify her husband of her abortion decision when no issue of potential abuse or other special circumstance is implicated. *Id.* at 974-76 (Rehnquist, C. J., dissenting).

D&X abortions not done to preserve maternal life or health, or when there is clearly no demonstrable differential health benefit in performing such an abortion). The inquiry need go no further.

III. NEBRASKA'S BAN ON "PARTIAL-BIRTH" ABORTION IS FACIALLY CONSTITUTIONAL UNDER A "LARGE FRACTION" TEST.

Even if the "large fraction" test was the right one to use, the Eighth Circuit failed to apply that test properly. The impropriety resulted from the court's failure to properly construe Nebraska's statute. When that test is applied to the Act as properly construed, it is plain that the Respondent has failed to carry his burden, and that the Act is constitutional.

At the outset, it is necessary to consider what the joint opinion meant by a "large fraction." Initially such an exercise seems to require the construction of a fractional number.[6] Following the construction of the fraction, a separate determination of whether the fraction is "large" is required. To construct a fraction, one must identify its numerator and denominator. According to *Casey*, the numerator consists of the women for whom the Act "operate[s] as a substantial obstacle to [the] woman's choice to undergo an abortion." 505 U.S. at 895. The denominator is the number of women for

6. The term "fraction" has been defined as "[o]ne or more aliquot parts of a unit or integer; the indicated quotient of one integer divided by another." WEBSTER'S NEW INTERNATIONAL DICTIONARY (2nd ed. unabridged) 1000.

whom the Act is "an actual rather than an irrelevant restriction." *Id.* This latter group is composed of women who would elect a partial birth abortion if Nebraska did not prohibit that procedure.

The Eighth Circuit makes no effort to quantify the two parts of the fraction under the reading of Nebraska's statute advanced by its law enforcement officials. Moreover, there is no evidence that would permit the conclusion that the resulting fraction is "large".[7] The absence of any such evidence means that the Respondent did not meet his burden.

Moreover, the evidence in this case affirmatively shows that the fraction is not large, but extremely small. First, as for the numerator, there are "no circumstances" in which a partial birth abortion is "the only option to save the life or preserve the health of the woman." 143 Cong. Rec. S4708 (daily ed. May 20, 1997) (statement of the American College of Obstetrics and Gynecology (hereafter "ACOG")) ("[a] select panel convened by ACOG could identify no circumstances under which this

7. *Casey* omits to identify the size at which a fraction becomes a "large fraction;" this omission supports the view that the Court did not supplant *Salerno*'s "no set of circumstances" test with the *Casey* Joint Opinion's "large fraction" test. What constitutes a "large fraction," absent further explanation, would be a quite subjective consideration. Perhaps nine out of ten (ninety percent) would qualify. Or, perhaps, judges serving in the lower federal courts will rely on considerations quite apart from *federalism* and *separation of powers* (the principles that underlie the "no set of circumstances" test) to make such a determination. But whatever the right dividing line might be, Respondent was not required to show that Nebraska's statutes crossed into that forbidden zone.

procedure, as defined above, would be the only option to save the life or preserve the health of the woman"). Thus, there is no circumstance in which the Act operates as a "substantial obstacle" to a woman's choice to undergo "an abortion." The numerator still is zero. Even indulging in speculation that there may be some hypothetical situation that never occurred to the select panel on which ACOG relied, the numerator must be very, very small.

As for the denominator, it may be supplied by facts that can be gleaned from experience in areas where physicians have offered D & X abortions.[8] The legislative history of the bill passed by the United States House of Representatives shows that, in New Jersey, "at least 1,500 partial-birth abortions are performed each year." H.R. Rep. No. 105-24, at 13 (hereafter "the Report") (citation omitted). Most are elective. Few, a "minuscule amount," are performed for medical reasons.[9] *Id.* The Report concludes that this information "refute[s] the

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8. The "large fraction" test also suffers from an additional defect. It is difficult to quantify empirically the number of women who would choose a partial birth abortion were it not for the Nebraska statute. This difficulty is real; what evidence will be offered in support of the claim? To the extent the problem cannot be solved by the evidence, it is those who challenge the statute who must lose since it is they who bear the burden of proof.

9. This reference to medically indicated cases refers to those cases where the underlying abortion decision was made for medical reasons and does not suggest that the decision to use the partial birth technique was ever medically indicated. Moreover, assuming *arguendo* that every medically indicated case was one where both the abortion and the partial birth procedure were medically necessary, a "miniscule" number is not a "large fraction" of the total partial birth abortions performed.

abortion advocates claims that partial-birth abortion was both rare and only performed in extreme medical circumstances." H.R. Rep. 105-24 at 13.

While Nebraska is smaller than New Jersey, the experience of that State is nevertheless relevant here. Given this denominator, and regardless of whether the numerator is zero or just very, very small, the resulting fraction falls far short of being "large" by any definition of the term. Thus, even under the "large fraction" test, the Nebraska Act passes constitutional muster.

IV. LIKE THEIR PREDECESSORS, *DRED SCOTT* AND *PLESSY*, *ROE* AND *CASEY* ARE FUNDAMENTALLY WRONG AND SHOULD BE REVERSED.

In 1857, this Court faced and failed a historic "teaching moment." Then, in *Dred Scott v. Sandford*, 60 U.S. 393 (1857), this Court concluded that, although he might be the citizen of *a State* by operation of the law of that State, an African in America was not, and could not be, a citizen of the *United States*. *Id.* at 406. Per force of that conclusion, Scott's federal suit was dismissed for lack of jurisdiction. Over a decade passed before the plain error and political illegitimacy of the *Dred Scott* decision was confirmed by the ratification of the Fourteenth Amendment to the United States Constitution. In the intervening period, the Chief Executive portended that the ongoing, bloody, civil war might

> continue until all the wealth piled by the bondsman's two hundred and fifty years of unrequited toil shall be sunk, and until every drop of blood drawn with the lash shall

> be paid by another drawn with the sword, as was said three thousand years ago, so still it must be said 'the judgments of the Lord are true and righteous altogether.'

A. Lincoln, Second Inaugural Address (Mar. 4, 1865) (quoting Psalm 19:9 (King James)), *reprinted in* INAUGURAL ADDRESSES OF THE PRESIDENTS OF THE UNITED STATES FROM GEORGE WASHINGTON 1789 TO GEORGE BUSH 1989, S. Doc. 101-10, p. 143 (1989).

In 1992, in *Casey*, this Court faced and failed yet another a historic teaching moment when it did not overrule *Roe v. Wade*. Except, perhaps, for *Dred Scott*, *Roe v. Wade* embodies the most startling judicial abrogation of civil rights ever wreaked by the Court. In *Roe*, this Court struck down Texas abortion statutes as a result of its apparent conclusion that prior to birth, the unborn human child is neither a citizen, nor a person, as those terms are used in the Fourteenth Amendment to the United States Constitution. Subsequent social upheaval and unrest demonstrated that, as with the *Dred Scott* decision, the Court had erred by denying basic civil and constitutional rights to an unrepresented, discrete and insular minority. *Casey* was an appropriate opportunity for this Court to undo the wrongs of *Roe*; this Court failed to correct its own earlier error.

In an effort at justification, the joint opinion in *Casey*, 505 U.S. at 861-66, asserts that *Roe* was of a kind with this Court's earlier decision in *Brown v. Board of Education*, 347 U.S. 483 (1954). In fact, *Roe* traces its descent to *Dred Scott* through *Plessy v. Ferguson*, 163 U.S. 537 (1896). *Dred Scott*, if it accomplished anything other guaranteeing that Mr. Scott would spend his remaining days in involuntary servitude, hardened

public opinions and helped to create the conditions under which insurrection became inevitable. It took a war that Abraham Lincoln considered a national judgment by God, and the Reconstruction Amendments, to remove the blot of that decision. *Plessy*, of a piece with *Dred Scott*, erected a hardened bunker within which color-dependent discrimination could blossom. This Court's decision in *Brown*, together with the decades-long, nonviolent, civilly disobedient opposition of African Americans was necessary to undo the segregation this Court legitimized and institutionalized in *Plessy*.

Like its predecessors, *Dred Scott* and *Plessy*, *Roe* did not resolve the social and legal controversy over the morality and legality of abortion. As this Court has elsewhere said, "[m]en and women of good conscience can disagree, and we suppose some always shall disagree, about the profound moral and spiritual implications of terminating a pregnancy, even in its earliest stage. Some of us as individuals find abortion offensive to our most basic principles of morality." *Casey*, 505 U.S. at 850.

In the present case, this Court has declined, quite specifically, to consider the *essential* question, whether *Roe* will fall at the Court's own behest. Instead, this Court has confined itself to a consideration of one State's legislative proscription of a particularly gruesome form of perinatal infanticide. The Court should take this opportunity, however, to reconsider its decision in *Roe* and its decision to sustain *Roe* in *Casey*.

CONCLUSION

For the reasons stated above and in Petitioners' brief, the judgment below should be reversed.

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No. 99-830

In the Supreme Court of the United States

DON STENBERG, ATTORNEY GENERAL OF THE STATE OF NEBRASKA, *ET AL.*,
Petitioners,

v.

LEROY CARHART, M.D.,
Respondent.

On Writ of Certiorari to the
United States Court of Appeals for the Eighth Circuit

BRIEF ON THE MERITS OF AMICUS CURIAE THE STATE OF TEXAS IN SUPPORT OF PETITIONERS

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On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF ON THE MERITS OF AMICUS CURIAE THE STATE OF TEXAS IN SUPPORT OF PETITIONERS

TO THE HONORABLE SUPREME COURT OF THE UNITED STATES:

This case presents the question of whether Nebraska's "partial birth abortion" statute creates an undue burden on the right to abortion. For the reasons that follow, amicus believes that this statute is constitutional and urges the Court to reverse the Eighth Circuit's judgment to the contrary.

INTEREST OF AMICUS

The State of Texas appears as amicus curiae and urges the Court to reverse the judgment of the Eighth Circuit. Although Texas does not have in place a statute prohibiting "partial birth abortions," Texas does have a "parturition" statute which prevents the killing of a child during birth if that child otherwise would have been born alive. *See* TEX. REV. CIV. STAT. art. 4512.5. The States of Louisiana and Mississippi are filing an amicus brief supporting Petitioner on the merits arguing that Nebraska's statute is not actually a statute regulating abortion but is, rather, a statute prohibiting the killing of a child during birth like Texas's parturition statute. Because its parturition statute has been brought into this debate, Texas has a substantial interest in the disposition of this case.

SUMMARY OF THE ARGUMENT

For more than one hundred years Texas has had a parturition statute in place that prohibits the killing of a child during birth. The States of Louisiana and Mississippi are filing an amicus curiae brief arguing that the Nebraska statute prohibiting partial birth abortions is not actually a statute regulating abortion, but is instead more related to a parturition statute that prevents the killing of a child during birth. Texas adopts and endorses the arguments made by Louisiana and Mississippi, and urges the Court to reverse the judgment of the Eighth Circuit.

ARGUMENT

Texas's parturition statute provides:

> "Whoever shall during parturition of the mother destroy the vitality or life in a child in a state of being born and before actual birth, which child would otherwise have been born alive, shall be confined in the penitentiary for life or for not less than five years." TEX. REV. CIV. STAT. art. 4512.5.

This statute existed when the Court considered *Roe v. Wade*, 410 U.S. 113 (1973), and it was not invalidated by that opinion. *See id.* at 117 n.1 (noting that article 4512.5, formerly article 1195, had not been challenged by Roe). Texas law has long-recognized that article 4512.5 "is not, in truth, an abortion statute," but is instead "a prohibition of a crime of its very precise definition." Op. Tex. Att'y Gen. No. H-369 at 3 (1974)[1] (citing *Hardin v. State*, 52 Tex. Crim. 238, 238, 106 S.W. 352, 353 (1907)). That distinction was noted at the reargument of *Roe*, when Justice Marshall noted that killing a child in the process of childbirth was "not an abortion." *See* Brief of Amici Curiae Louisiana and Mississippi in Support of Petitioner, Appendix A at 3 (transcription of the second argument of *Roe*).

Although Texas has not enacted a statute specifically prohibiting "partial birth abortions" as have Louisiana and Mississippi, Texas agrees with and endorses the arguments made by those states in interpreting article 4512.5 as set forth in their amicus brief on the merits.

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1. Texas Attorney General Opinions can be obtained from the Texas Attorney General's website, which is located at http://www.oag.state.tx.us.

CONCLUSION

For these reasons, and those set out in the Brief of Amici Curiae Louisiana and Mississippi in Support of Petitioner, Texas respectfully requests that the Court reverse the judgment of the Eighth Circuit.

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On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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Rep. Charles T. Canady
Rep. Helen Chenoweth-Hage
Rep. Dr. Tom Coburn, M.D.
Rep. Tom DeLay
Rep. John T. Doolittle
Rep. Virgil H. Goode
Rep. Bob W. Goodlatte
Rep. Mark Green
Rep Ralph Hall
Rep. Tony Hall
Rep. Robert Hayes
Rep. Van Hilleary
Rep. Peter Hoekstra
Sen. Tim Hutchinson
Rep. Henry Hyde
Rep. Peter King
Rep. Steve Largent
Rep. David M. McIntosh
Rep. Sue Myrick
Rep. Jim Ryun
Sen. Rick Santorum
Rep. James Sensenbrenner
Sen. Bob Smith
Rep. Christopher H. Smith
Rep. James Talent
Rep. Lee Terry
Rep. Dr. Dave Weldon, M.D.

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INTEREST OF AMICI CURIAE[1]

Amici Curiae are members of the United States Congress who have been key sponsors of legislation to ban partial-birth abortion.

SUMMARY OF THE ARGUMENT

Nebraska's partial-birth abortion ("PBA") ban is directly patterned after a 1997 bill in Congress, a refinement of a 1995 bill, making the federal bills in pari materia for construing Nebraska's law. The history of congressional efforts to ban PBA shows that only a new procedure was targeted – one publicized by Dr. Martin Haskell and now also known as intact dilation and extraction ("intact D&X") – not conventional abortion methods. The federal bills received support even from prominent members of Congress who identify themselves as pro-choice – further indicating both that there was no congressional intent to ban conventional abortions and that PBA is beyond what most Americans perceive as "abortion." It would be a radical extension of *Casey* to expand it to reach a partial-birth killing procedure that Congress (along with most Americans and States) does not even consider to be "abortion."

The federal PBA bills were founded on the premise that the change in the partially-born child's location triggers heightened state interests in protecting the child and that this

---

[1]**Rule 37.6:** Amici Curiae disclose that (1) no counsel for a party authored this brief in whole or in part and (2) the National Right to Life Committee made a monetary contribution to the preparation and submission of this brief. **Rule 37.3(a):** Petitioners and Respondent consented to the filing of this brief. Consent letters have been provided to the Clerk.

Court's abortion jurisprudence does not govern "parturition,"[2] but only situations where a child is "unborn." The federal PBA bill was also premised on the congressional finding, after extensive testimony, that the PBA procedure is never medically indicated and that there are conventional abortion procedures that do not involve the killing of a living, partially-born child. Therefore, even if this Court's abortion decisions apply in the PBA context, there is no undue burden.

ARGUMENT

I. The History of Congressional Efforts to Ban Partial-Birth Abortion Reveals That Only the Intact D&X Procedure Was Targeted.

Nebraska's PBA ban is patterned after a 1997 bill passed by both houses of the United States Congress.[3] This makes the Nebraska ban in pari materia with the federal bill for purposes of determining the targeted activity and historical context of the Nebraska ban. *See, e.g., Michigan Nat'l Bank v. Michigan* 365 U.S. 467 (1961) (federal Home Owner's Loan Act of 1933 held to be in pari materia with subsequently enacted Michigan savings and loan tax statute). *Cf.* 2 *Sutherland on Statutory Construction* § 53.03 (rev. 5th ed. 1992) ("[T]he interpretation of a doubtful statute may be influenced by language of other statutes which are not specifically related, but which apply to similar persons, things, or relationships.")

A prior version of the federal bill was passed by both houses of Congress in 1995. Many state legislatures have followed the pattern of these two bills and passed bills barring *partial-birth abortion*, a legal term of art for a procedure in which a living intact infant is partially, vaginally delivered, then killed before being completely removed from the birth canal.

When the described procedure became widely known in 1994, there was immediate controversy. Legislative efforts to ban it began in June 1995. Congressional hearings were held, and a federal bill was passed and vetoed by President Clinton with much publicity. *See Partial-Birth Abortion Ban Act of 1995*, H.R. Rep. No. 104-267 (1995). Nearly two-thirds of the States have enacted bills patterned after the federal bills.[4]

A. *Dr. Haskell Ignited the Controversy.*

On September 13, 1992, Dr. Martin Haskell, an abortion provider who operates three abortion clinics, presented *Dilation and Extraction for Late Second Trimester Abortion* (hereinafter "*Haskell Monograph*"), at the National Abortion Federation's two-day Fall Risk Management Seminar (Dallas, Texas) entitled *Second Trimester Abortion: From Every Angle* (appended as *Appendix A*). The monograph and numerous other materials on PBA were collected and published as the record of hearings before the U.S. Senate Judiciary Committee on the Partial-Birth Abortion Ban Act of 1995. *See The Partial-Birth Abortion Ban Act of 1995: Hearing on H.R. 1833 Before the Senate Comm. on the Judiciary*, 104th Cong. 3 (Nov. 17, 1995) [hereinafter "*1995 Senate Hearings*"].

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[2]"Parturition" is "the action or process of giving birth . . . ." *American Heritage College Dictionary* 997 (1993).

[3]*See also* James Bopp, Jr., J.D. & Curtis R. Cook, M.D., *Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence*, 14 Issues in Law & Medicine 3 (1998).

[4]*See* Brief of Amici Curiae Alabama, Iowa, Louisiana, et al. in Support of Petitioners at 16 n.11, *Stenberg v. Carhart*, No. 99-830 (this case; brief supporting cert.) (listing states enacting PBA bans).

In his paper, Dr. Haskell, who has done over 1,000 partial-birth abortions, described a procedure in which he used ultrasound guidance to partially extract a living fetus feet-first, then punctured the baby's skull and suctioned the cranial contents before completing the extraction. *See id.* at 7-8 (*Haskell Monograph*). He described the procedure as "a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia." *Id.* at 11. Dr. Haskell (a family practitioner, not an obstetrician-gynecologist) wrote that he "routinely performs this procedure on all patients 20 through 24 weeks" (4½ to 5½ months) pregnant, but excludes women who are more than 20 pounds overweight, have twins, or have certain other complicating factors. *See id.* at 6-7.

Dr. Haskell provided precise detail of the critical part of the procedure:

> With a lower [fetal] extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities.
>
> The skull lodges at the internal cervical os. Usually there is not enough dilation for it to pass through. The fetus is oriented dorsum or spine up.
>
> At this point, the right-handed surgeon slides the fingers of the left hand along the back of the fetus and "hooks" the shoulders of the fetus with the index and ring fingers (palm down). . . . [T]he surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger.
>
> Reassessing proper placement of the closed scissors tip . . . the surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening.
>
> The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies traction to the fetus, removing it completely from the patient.

Id. at 8-9.

In a 1993 interview with *Cincinnati Medicine*, Dr. Haskell explained why he had adopted the method. He had been performing dismemberment abortions (D&Es) to 24 weeks:

> But they were very tough. Sometimes it was a 45-minute operation. I noticed that some of the later D&Es were very, very easy. So I asked myself why can't they all happen this way. You see the easy ones would have a foot[ling] presentation, you'd reach up and grab the foot of the fetus, pull the fetus down and the head would hang up and then you would collapse the head and take it out. It was easy. . . . Then I said, "Well gee, if I just put the ultrasound up there I could see it all and I wouldn't have to feel around for it." I did that and sure enough, I found it 99 percent of the time. Kind of serendipity.

Second Trimester Abortion: An Interview With W. Martin Haskell, M.D., 16 Cincinnati Med. 18, 19 (1993).

In 1993, the *American Medical News* – the official newspaper of the AMA – conducted a tape-recorded interview with Dr. Haskell concerning this specific abortion method in which he indicated that two-thirds of the partially-born children

on which he performed his procedure were not dead before he began to remove them:

> **Am. Med. News:** Let's talk first about whether or not the fetus is dead beforehand . . .
>
> **Haskell:** No it's not. No, it's really not. A percentage are for various numbers of reasons. Some just because of the stress – intrauterine stress during, you know, the two days that the cervix is being dilated. Sometimes the membranes rupture and it takes a very small superficial infection to kill a fetus in utero when the membranes are broken. And so in my case, I would think probably about a third of those are definitely are (sic) dead before I actually start to remove the fetus. And probably the other two-third are not.

1995 Senate Hearings at 22-24 (Letter from Barbara Bolsen (Editor of *American Medical News*) to the Hon. Charles T. Canady (Chairman, Subcomm. on the Constitution, Comm. on the Judiciary) (July 11, 1995) (attaching transcript of interview with Dr. Haskell from which quotation was taken)).

Concerning the possibility of simply delivering the child alive, Dr. Haskell indicated that such a result was a possibility, but that it was not his goal:

> The point here is to effect a safe legal abortion. . . . I could put dilapan in for four or five days and say I'm doing a D&E procedure and the fetus could just fall out. But that's not really the point. The point here is you're attempting to do an abortion. And that's the goal of your work, is to complete an abortion. Not to see how do I manipulate the situation so that I get a live birth instead.

Id. at 23.

Dr. Haskell also indicated that the overwhelming number of his partial-birth abortions were elective:

> And I'll be quite frank: most of my abortions are elective in that 20-24 week range. . . . In my particular case, probably 20% [of this procedure] are for genetic reasons. And the other 80% are purely elective.

Id.

In a lawsuit in 1995, Dr. Haskell testified that women come to him for partial-birth abortions with "a variety of conditions. Some medical, some not so medical." *Id.* at 28 (Transcript of testimony of Dr. Haskell on Nov. 8, 1995, *in Women's Med. Prof. Corp. v. Voinovich*, 911 F. Supp. 1051 (S.D. Ohio 1995)). Among the medical examples he cited was "agoraphobia" (fear of open places). *See id.* at 29. Moreover, in testimony presented to the Senate Judiciary Committee on November 17, 1995, OB/GYN Dr. Nancy Romer of Dayton (a city in which Dr. Haskell operates an abortion clinic) testified that three of her own patients had gone to Haskell's clinic for abortions "well beyond" five months into pregnancy, and that "[n]one of these women had any medical illness and all three had normal fetuses." *Id.* at 109 (statement of Nancy G. Romer, M.D.).

Brenda Pratt Shafer, a registered nurse who observed Dr. Haskell use the procedure to abort three babies in 1993, testified that one little boy had Down's syndrome, while the other two babies were completely normal and their mothers were healthy. *See id.* at 18-19 (statement of Brenda Pratt Shafer, R.N.). In 1995 testimony before the U.S. Senate Judiciary Committee, she described a partial-birth abortion she witnessed on a child of 26½ weeks as follows:

> Dr. Haskell brought the ultrasound in and hooked it

up so that he could see the baby. On the ultrasound screen, I could see the heart beat. As Dr. Haskell watched the baby on the ultrasound screen, the baby's heartbeat was clearly visible on the ultrasound screen.

Dr. Haskell went in with forceps and grabbed the baby's legs and pulled them down into the birth canal. Then he delivered the baby's body and the arms – everything but the head. The doctor kept the head right inside the uterus. . . .

The baby's little fingers were clasping and unclasping, and his little feet were kicking. Then the doctor stuck the scissors in the back of his head, and the baby's arms jerked out, like a startle reaction, like a flinch, like a baby does when he thinks he is going to fall.

The doctor opened up the scissors, stuck a high-powered suction tube into the opening, and sucked the baby's brains out. Now the baby went completely limp. . . . That baby boy had the most perfect angelic face I think I have ever seen in my life.

Id. at 18.

Dr. Haskell's intact D&X procedure was the clear target of congressional efforts to ban partial-birth abortion. A drawing of the procedure was used in the hearings and recurs in congressional hearing records. *See, e.g., Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 Before the Sen. Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 105th Cong. 56 (1997) (appended as *Appendix B*).

B. *Dr. McMahon Fueled the Conflict.*

The late Dr. James McMahon performed thousands of

partial-birth abortions. Dr. McMahon's writings cite a number of indications for performing the D&X procedure "for health reasons": cleft lip, 2 vessel cord (most commonly associated with a normal infant), too little or too much fluid (variations from the norm are not uncommon, and typically not associated with birth defects), exposure to a teratogen (a substance that can cause a birth defect, of which most have a low probability for effect), etc. He also cites depression, minor maternal complications, and even a small pelvis as separate indications to kill the baby in advanced gestation. *See Partial-Birth Abortion: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. 110-15 (June 15, 1995) [hereinafter "*Partial-Birth Abortion*"] (Appendix 3 – Letter from Jim McMahon, M.D., to Keri Harrison (assistant counsel, Subcommittee on the Constitution) (June 8, 1995) (attaching charts of "Fetal Indications" for abortions he performed)).

Dr. McMahon also gave testimony about the reasons why he does partial-birth abortions. In June, 1995, Dr. McMahon submitted to Congress a detailed breakdown of a "series" of over 2,000 of these abortions that he had performed. He classified only 9% (175 cases) as involving "maternal [health] indications," of which the most common was "depression." *Id.*

Dr. Pamela E. Smith, director of Medical Education, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, Chicago, gave the Senate Judiciary Committee her analysis of Dr. McMahon's 175 "maternal indication" cases. Of this sample, Smith noted that 39 cases (22%) were for maternal "depression," while another 16% were "for conditions consistent with the birth of a normal child (e.g., sickle cell trait, prolapsed uterus, small pelvis)." She added that in one-third of the cases, the conditions listed as "maternal indications" by Dr. McMahon really indicated that the procedure itself would be

seriously risky to the mother. *1995 Senate Hearings* at 82 (prepared statement of Pamela Smith, M.D.).

Of Dr. McMahon's series, 1,183 cases (about 56%) were for "fetal flaws," but these included a great many non-lethal disorders, such as cleft palate and Down's syndrome. *See Partial-Birth Abortion* at 110-15. In an op ed piece written for the *Los Angeles Times*, Dr. Katherine Dowling, a family physician at the University of Southern California School of Medicine, examined Dr. McMahon's report on this "fetal flaws" group:

> Twenty-four were done for cystic hy[g]roma (a benign lymphatic mass, usually treatable in a child of normal intelligence). Nine were done for cleft lip-palate syndrome (a friend of mine, mother of five, and a colleague who is a pulmonary specialist were both born with this problem). Other reasons included cystic fibrosis (my daughter went through high school with a classmate with cystic fibrosis) and duodenal atresia (surgically correctable, but many children with this problem are moderately mentally retarded). Guess they can't enjoy life, can they? In fact, most of the partial-birth abortions in that [McMahon] survey were done for problems that were either surgically correctable or would result in some degree of neurologic or mental impairment, but would not harm the mother. Or they were done for reasons that were pretty skimpy: depression, chicken pox, diabetes, vomiting.

Katherine Dowling, *What Constitutes A Quality of Life?: Neither Treatable Conditions Nor Permanent Handicaps Mean People Can't Live Useful, Happy Lives*, L.A. Times, Aug. 28, 1996, at B9.

C. *Congress Reacted with a Ban on Partial-Birth Abortions.*

In response to the emerging news that PBAs were being done, the Partial-Birth Abortion Ban Act (H.R. 1833) was introduced in the U.S. Congress in June, 1995. *See Partial-Birth Abortion Ban Act of 1995*, H.R. Rep. No. 104-267 (Sept. 27, 1995). This led to the hearings cited above, which provided an immense amount of legislative evidence on PBA practice.

On December 7, 1995, the U.S. Senate approved the final version of the federal bill by a vote of 54-44. *See* Cong. Rec. S18228, roll call #596 (Dec. 7, 1995). The House of Representatives approved the bill on March 28, 1996, by a vote of 286-129. *See* Cong. Rec. H2929, roll call #94 (Mar. 28, 1996). On April 10, 1996, President Clinton vetoed the bill. *See* Cong. Rec. H3338-3339, H. Doc. 104-198 (Apr. 10, 1996). An override vote in the House obtained the necessary votes for an override, but the vote in the Senate fell short of the two-thirds majority needed. *See* Cong. Rec. H10642, roll call #422 (votes: 285-137) (Sept. 19, 1996); Cong. Rec. S11337-11361, roll call #301 (votes: 57-41) (Sept. 26, 1996).

After the vote, more information about the practice of PBA became available, which altered the debate. For example, Ron Fitzsimmons (head of the National Coalition of Abortion Providers) admitted in an interview with *American Medical News* (and then numerous other news outlets) that he had "lied through his teeth" when he "spouted the party line" on *ABC News Nightline*, by claiming that the annual number of PBAs was only 500 instead of the 3,000 to 5,000 he now admits. *See* Diane M. Gianelli, *Medicine Adds to Debate on Late-Term Abortion: Abortion Rights Leader Urges End to 'Half Truths,'* Am. Med. News, Mar. 3, 1997, at 3, 28; Ruth Padawer, *Pro-Choice Advocates Admit to Deception*, Sunday Record, Feb. 27,

1997; David Stout, *An Abortion Rights Advocate Says He Lied About Procedure*, N.Y. Times, Feb. 26, 1997, at A12.

A PBA bill was reintroduced in Congress, adding the "substantial portion" language that also appears in Nebraska's PBA ban in a further effort to assure that the bill would not chill performance of conventional abortions, thereby gaining the American Medical Association's endorsement. *See infra* note 6. The bill passed the House of Representatives on March 20, 1997, by more than a two-thirds vote, and the Senate on May 20, by a vote of 64-36. *See* Cong. Rec. H1231, roll call #65 (votes: 295-136) (Mar. 20, 1997); Cong. Rec. S4715, roll call #71 (May 20, 1997). The bill was vetoed by the President. *See* Cong. Rec. H8891-8892, H.Doc. 105-158 (Oct. 10, 1997). The House readily overrode the veto, while the Senate fell just short of an override. *See* Cong. Rec. H6212-13, roll call #325 (votes: 296-132) (July 23, 1998); Cong. Rec. S10564, roll call #227 (votes: 64-36) (Sept. 18, 1998). This 1997 bill was the pattern for Nebraska's law.[5]

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[5]That the federal bill and Nebraska's act are in pari materia is self-evident from a comparison of Nebraska's ban with the following 1997 federal model language:

> Sec. 1531 Partial-birth abortions prohibited.
>
> (a) Any physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than two years, or both. This paragraph shall not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury. This paragraph shall become effective one day after enactment.
>
> (b)(1) As used in this section, the term 'partial- birth abortion' means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and

(continued...)

The history of the debates over these bills is illuminating and certain myths advanced in the debates deserve brief note. These myths were part of an organized misinformation campaign by abortion-rights groups, which experienced a serious setback in late January, 1997, with the release of an edition of the Public Broadcasting System media-criticism program *Media Matters*.[6] The program, which examined the press coverage of

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[5](...continued)
completing the delivery.

> (2) As used in this section, the term 'physician' means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the doctor performs such activity, or any other individual legally authorized by the State to perform abortions: Provided, however, that any individual who is not a physician or not otherwise legally authorized by the State to perform abortions, but who nevertheless directly performs a partial-birth abortion, shall be subject to the provisions of this section.
>
> (3) As used in this section, the term 'vaginally delivers a living fetus before killing the fetus' means deliberately and intentionally delivers into the vagina a living fetus, or a substantial portion thereof, for the purpose of performing a procedure the physician knows will kill the fetus, and kills the fetus.

Partial-Birth Abortion Ban Act of 1997, H.R. 1122, 105th Cong., § 1531 (a) & (b) (Oct. 9, 1997).

[6]A videotape of the program was played at a joint congressional PBA hearing in 1997. *See Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 Before the Sen. Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 105th Cong. 16 (1997). *Media Matters* described itself as "a series that looks critically at news media performance." The program was hosted by executive editor Alex Jones, a Pulitzer Prize-winning journalist who also hosts National Public Radio's weekly show *On the Media*. The investigation of PBA coverage was reported by Terry Eastland, editor of *Forbes MediaCritic Online*, and produced by two-time Emmy documentary

(continued...)

PBA issues, concluded that portions of the major media had demonstrated serious bias by uncritically adopting the misinformation provided by the abortion-rights advocacy groups on PBAs.

1. Myth #1: PBAs are only done in extreme cases involving serious fetal deformities or threat to the life of the mother.

In the debate over the federal PBA ban, opponents of the ban argued that PBAs are extremely rare and only done "late term" in extreme cases involving serious fetal deformities or threat to the life of the mother. *See, e.g.*, Ann Devroy, *Late-Term Abortion Ban Vetoed*, Wash. Post, Apr. 11, 1996, at A1. As seen from the discussion of the practice of Drs. Haskell and McMahon, *supra*, it is clear that the substantial majority of partial-birth abortions are performed late in the second trimester – before the 27-week mark, but usually after 20 weeks (4½ months) – and the overwhelming majority are performed for purely nonmedical reasons.

2. Myth #2: Banning PBA would jeopardize the health of women.

In the debate over the federal PBA bills, the assertion was often made that PBAs are necessary to protect the health of women. In the Spring of 1997, however, the American Medical Association came out in support of the federal bill to ban PBA, which, as the AMA Executive Vice President said for the Association, is "not medically indicated" and "is not good

[6](...continued)
nominee Joseph Dorman.

medicine."[7]

3. Myth #3: The anesthesia given to the mother kills the baby or renders the baby pain-free before the procedure is done.

Another piece of misinformation asserted by opponents of the federal PBA ban was that the partially-born victim of cranial decompression was either dead or pain free during the procedure as a result of anesthesia given to the mother.[8] This myth was quickly and emphatically debunked by anesthesiologists. *See* Diane M. Gianelli, *Anesthesiologists Question Claims in Abortion Debate*, Am. Med. News, Jan. 1, 1996, at 4; *1995 Senate Hearings* at 225-26 (Letter from Norig Ellison, M.D. (American Society of Anesthesiologists) to Hon.Orrin G. Hatch (Chairman, Sen. Comm. on the Judiciary) (Nov. 22, 1995)).

[7]Letter from P. John Seward, M.D., Executive Vice President, American Medical Association, to U.S. Sen. Rick Santorum (May 19, 1997) ("The American Medical Association (AMA) is writing to support H.R. 1122, 'The Partial-Birth Abortion Ban Act of 1997.' Although our general policy is to oppose legislation criminalizing medical practice or procedure, the AMA has supported such legislation where the procedure was narrowly defined and not medically indicated. . . . Thank you for the opportunity to work with you toward restricting a procedure we all agree is not good medicine.").

[8]Kate Michelman, President of the abortion-rights group NARAL insisted this in numerous fora, including comments on KMOX-AM radio, St. Louis, Mo., on Nov. 2, 1995. This claim was widely accepted and reported as fact in news stories and editorial commentaries (e.g., by Ellen Goodman). Likewise, Planned Parenthood Federation of America distributed to Congress a "fact sheet" signed by Dr. Mary Campbell, Medical Director of Planned Parenthood of Metropolitan Washington, DC, which asserted the claim. *See* Mary Campbell, *H.R. 1833: Medical Questions and Answers* (October, 1995).

4. Myth #4: A fetus is incapable of feeling pain due to lack of development.

Proponents of PBA also asserted that a fetus was not sufficiently developed to experience pain from the procedure, which assertion was quickly rejected by the experts. At Congressional hearings in June, 1995, brain surgeon Robert J. White testified that "[b]y the 20th week of gestation and beyond, the fetus has in place the neurocircuitry to appreciate pain," and that "there are studies that demonstrate even at 8 weeks through 13 weeks[] there's enough neurocircuitry present so that pain and noxious stimuli could be perceived." *Partial-Birth Abortion* at 67. In fact, "some authorities feel that fetuses at this age [beyond 20 weeks] can perceive pain to a greater degree than the adult." *Id.*

D. *Many Pro-Choice Legislators Joined Efforts to Ban PBA.*

PBA bills in Congress passed by margins much larger than would be possible if only those who identified themselves as pro-life were voting in support. *See supra* I.C. Many who identified themselves as pro-choice supported the PBA bans.

Examples include House Democratic Leader Rep. Richard Gephardt and Sen. Patrick Leahy, who voted to override the President's veto. *See*, *e.g.*, Letter from Rep. Richard A. Gephardt to C.J. Vennemann, Jr. (August 2, 1996) (on file with Amici counsel) ("You may be assured that I will continue to oppose this late-term abortion procedure and vote to override the Presidential veto when this again comes to the House Floor."); Cong. Rec. S11356 (Sen. Leahy: "[m]y conscience alone, must determine my vote. I will vote to override."). In his speech in favor of overriding the President's veto, Sen. Specter declared that his vote did "not affect [his] basic views on the

pro-choice/pro-life issue," but that "the line of the law is drawn, in [his] legal judgment, when the child is partially out of the womb of the mother. It is no longer abortion; it is infanticide." Cong. Rec. S11375.

Normally pro-choice Sen. Daniel Patrick Moynihan also voted to override the President's veto, and was quoted as follows: "At the time, I remarked that the procedure was too close to infanticide . . . and now we have testimony that it is not just too close to infanticide, it is infanticide, and one would be too many." Congressional Quarterly, *Moynihan: Clinton turnabout likely Senator says veto OK'd infanticide*, CQ's Washington Alert, March 15, 1997, Item 1 at 2.

This support from abortion-rights supporters indicates both (1) that the PBA bans do not target conventional abortion procedures and (2) that for many who support abortion rights PBA is not what they mean by "abortion."

E. *Recent Senate Action Reveals Support for Abortion Rights But Opposition to PBA.*

Recently, the Senate passed S. 1692, another bill banning PBA. *See* Cong. Rec. S12997, roll call #340 (votes: 63-34) (Oct. 21, 1999). It reveals precisely the point made in this brief, namely, there is ongoing opposition to PBA amid congressional support for abortion rights.

The Senate bill was modified to assure that the language banning PBA does not reach the dilation and evacuation (D&E) and other conventional abortion procedures. It also contained three statements of the sense of Congress.

The first, a "Sense of Congress Concerning Roe v. Wade and Partial Birth Abortion Bans," stated the following:

(a) FINDINGS – Congress finds that –

(1) abortion has been a legal and constitutionally protected medical procedure . . . since the Supreme Court decision in Roe v. Wade . . .; and

(2) no partial birth abortion ban shall apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury.

(b) SENSE OF CONGRESS – It is the sense of the Congress that partial-birth abortions are horrific and gruesome procedures that should be banned.

Id. at § 3.

The second, a "Sense of the Congress Concerning a Woman's Life and Health," provided as follows:

(a) It is the sense of the Congress that, consistent with the Supreme Court, a woman's life and health must always be protected in any reproductive health legislation passed by Congress.

Id. at § 4.

The third, a "Sense of the Congress Concerning Roe v. Wade," made the following statement:

(a) FINDINGS – Congress finds that –

(1) reproductive rights are central to the ability of women to exercise their full rights under Federal and State law;

(2) abortion has been a legal and constitutionally protected medical procedure . . . since the Supreme Court decision in Roe . . .;

(3) the 1973 Supreme Court decision in Roe v. Wade

established constitutionally based limits on the power of States to restrict the right of a woman to choose to terminate a pregnancy; and

(4) women should not be forced into illegal and dangerous abortions as they often were prior to the Roe v. Wade decision.

(b) SENSE OF THE CONGRESS – It is the sense of the Congress that –

(1) Roe v. Wade was an appropriate decision and secures an important constitutional right; and

(2) such decision should not be overturned.

Id. at § 5.

Again it is evident both that (1) PBA bans do not target conventional abortion procedures and (2) for many who support abortion rights "abortion" does not include PBA. It would be a radical extension of *Casey* to expand it to reach a partial-birth killing procedure that Congress (along with most Americans and States) does not even consider to be "abortion."

II. The Legal Premise of Federal and State Partial-Birth Abortion Bans Is That This Court's Abortion Jurisprudence Does Not Apply During Parturition, But Even if it Does Such Bans Comport with That Jurisprudence.

The federal PBA bills, upon which Nebraska's ban and most other state bans are modeled, were premised in part on the belief that this Court's abortion jurisprudence does not govern a statute involving partial-birth or parturition, but, even if it does govern, there is no "undue burden" on the abortion right.

See H.R. Rep. No. 104-267, at 9 (1995)[9] (the report of the House Committee on the Judiciary recommending passage of Partial-Birth Abortion Ban Act of 1995); *The Partial Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the Sen. Comm. on the Judiciary*, 104th Cong. 172 (Nov. 17, 1995) (written Testimony of Prof. Douglas W. Kmiec).

A. *This Court's Decisions Regarding the Right to Abort "Unborn Children" Do Not Apply to Laws that Prohibit the Killing of Partially-Born Children.*

The belief that this Court's abortion jurisprudence does not apply to a PBA statute arises from the fact that the constitutional equation has changed with the changed location of the child. The abortion right involves an "unborn" human being (not one partially born) and the termination of a pregnancy (which arguably has ended when a child is partially delivered). Therefore, there could be no "undue burden" under a *Casey* analysis because a *Casey* analysis would not apply.

This Court's own decisions reflect the fact that the constitutional balance is affected by the partial birth of the

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[9]The twelve-page report discussed the constitutionality of the partial-birth abortion ban under various levels of scrutiny. It declared that:

> This Supreme Court has never decided the constitutional status of a child in the process of being born. But even under *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, H.R. 1833, the "Partial-Birth Abortion Ban Act of 1995," is constitutional both before and after fetal viability. . . . In fact, in *Roe* this Court specifically noted that a Texas statute that made killing a child during the birth process a felony had not been challenged. . . .

Partial-Birth Abortion Ban Act of 1995, H.R. Rep. No. 104-267, at 9 (Sep. 27, 1995).

child. In *Roe v. Wade*, 410 U.S. 113 (1973), this Court held that the Texas anti-abortion statute at issue was unconstitutional, but the Court also noted that another Texas statute that bans killing children in parturition was unchallenged and unaffected. As quoted by the Court, this statute provides as follows:

> Art. 1195. Destroying unborn child. – Whoever shall during parturition of the mother destroy the vitality or life in a child in a state of being born and before actual birth, which child would otherwise have been born alive, shall be confined in the penitentiary for life or for not less than five years.

Id. at 118 n.1. The Texas parturition statute remains operative. Tex. Rev. Civ. Stat. Ann. art. § 4512.5 (West 1996). *See* Tex. Att'y Gen. Opinion H-369 (Aug. 13, 1974) (Texas parturition statute unaffected by *Roe)*; *Showery v. Texas*, 690 S.W.2d 689, 692 (Tex. Ct. App. 1985) (Texas parturition statute retains "current viability").[10]

If abortion jurisprudence does not apply in situations where a child is partially born, PBA bans must be upheld as rationally related to legitimate State interests unless this Nation's history and traditions have recognized a fundamental right to kill a partially born child. *See Washington v. Glucksberg*, 521 U.S. 702, 720 (1997). The Texas parturition statute illustrates that no such right has ever been recognized. There being no fundamental right, the State can readily demonstrate that a ban on killing children in parturition is rationally related to a legitimate state interest, *see infra*, and the PBA ban

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[10]The plain language of the Texas law requires only that the child in parturition "would otherwise have been born *alive*," not that the child be "*viable*." The partial-birth abortion statutes likewise are not limited to viable children.

must be upheld.

B. *Even if this Court's Abortion Decisions Apply, Partial-Birth Abortion Bans Further the Heightened Governmental Interest in Protecting Partially-Born Children and Do Not Place an Undue Burden on Any Abortion Right.*

The partial-birth abortion bans are based on the premise that States have a compelling interest in protecting the actual life of a child in the process of birth that is greater than, and distinguishable from, a state's interest in the "potential life" of a fetus in utero, which this Court has termed "substantial." *Casey*, 505 U.S. at 876. As the Wisconsin District Court found,

> when the physician kills a child in a partial birth abortion, the child "is merely inches from being delivered and obtaining full legal rights of personhood under the US Constitution." Accordingly, . . . partial birth abortion is "closer to infanticide than it is to abortion." The [Wisconsin State] legislators who filed an amicus brief [in the District Court] make similar arguments. The Court concludes that these facts demonstrate that the Act serves compelling state interests.

Planned Parenthood of Wis. v. Doyle, 44 F. Supp. 2d 975, 982 (W.D. Wis. 1999) (citations omitted).

It logically follows from this Court's abortion decisions that the interest in protecting the life of the child in the process of birth arises from the change of legal status the fetus undergoes as she changes location, emerging from the maternal body toward complete birth. *Roe* affirmed the constitutional significance of the locational change that occurs as the child emerges from the maternal body.

The child who has been completely born is a fully legal person, and the abortion liberty can make no claim on such a child's life. *See Roe*, 410 U.S. at 156-57. Similarly, it follows that the child who is partially born is the subject of a compelling state interest, and any asserted abortion liberty holds, at most, diminished power over such a child.

This is evident from examination of common definitions. "Birth" is "1.a. The emergence and separation of offspring from the body of the mother. b. The act or *process* of bearing young, parturition" *American Heritage College Dictionary* 141 (1993) (emphasis added); *see also Black's Law Dictionary* 154 (5th ed. 1979) ("Birth" is "*[t]he act of being born* or wholly brought into separate existence.") (emphasis added); *id.* at 167 ("Born" is the "*[a]ct of being delivered* or expelled from mother's body, whether or not placenta has been separated or cord cut.") (emphasis added).

These definitions clearly apply to a child who has fully emerged from her mother's body – she is obviously "born." But they also apply to a child in the "*process*" of "being born," in the *"act of being delivered,"* who also falls within these common definitions of "birth" and "born." Therefore, Nebraska (and Congress) may properly conclude that such a child is no longer "unborn" – no longer under the sway of the *Casey* abortion liberty – and that the State has a heightened interest in protecting the life of the partially-born child.

This Court has acknowledged that a State's interest in the life of a fetus grows as the fetus becomes able to survive apart from the mother's body – as the fetus becomes "viable." *See Roe*, 410 U.S. at 163-64; *Casey*, 505 U.S. at 875-76. Likewise, a State's interest in protection of the life of an unborn child increases and becomes compelling as she emerges from the maternal body and proceeds toward full birth, reaching its

apogee when live birth is completed. As the length of gestation has jurisprudential significance, so does location, and it is on the basis of the child's change in *location* that governments may assert a distinct compelling interest in protection of human life in the process of birth.

In the typical intact D&X abortion – the only procedure to which a properly construed partial-birth abortion statute applies – the child is delivered in a breech position, and only the child's head remains within the uterus. Much of the remainder of the child's body exists entirely outside the body of the woman. *See* Report of the AMA Board of Trustees ("One feature that distinguishes the D&X procedure from other destructive procedures is that the fetus may be partly outside the woman's body."). Surely, a State may conclude that such a child is no longer "unborn" and that the process of birth has proceeded to such a point that a state's interest in protection of the child has become compelling. "[T]he State cannot be faulted for acting where it can to outlaw an unnecessary procedure that in most cases in which it is used is literally inches away from being infanticide." *Doyle*, 44 F. Supp. 2d at 984.

Certainly, there is no precedent from this Court and there is no explicit language in the Constitution that precludes a State from determining that a child in the process of birth warrants special protection as the subject of a compelling state interest. This Court has simply not addressed the issue.

Nor has this Court held that gestational development/viability are the *exclusive* criteria by which the Constitution allows the State to measure its interest in the protection of human life. "Although abortion laws are typically justified according to the state's interest in maternal health or potential life, the *Casey* court specifically recognized that 'other valid state interest[s]' could justify a pre-viability abortion restric-

tion.'" *Doyle*, 44 F. Supp. 2d at 983 (quoting *Casey*, 505 U.S. at 877). In fact, it would be absurd to posit that the mere potential to live outside the womb – viability – has constitutional significance, while the actual fact of emergence of a living child from the womb has none whatever.

In short, a State may assert a distinct compelling interest in the protection of children in the process of birth that would overcome even a fundamental right to choose abortion. This locational interest exists apart from the substantial and compelling interests that the State might properly assert in "potential" human life based on gestational development, and it warrants special protection of the partially-born child.

And just as the fully born child – whether "viable" or not – is the subject of a compelling governmental interest in the protection of the child's life, based solely on the locational change the child has undergone, so also the child in the process of birth – whether "viable" or not – is the subject of a compelling state interest by virtue of the child's change in location

Furthermore, the abortion right wanes as a State's interest in protecting a partially born child waxes. This Court has recognized only a right to terminate pregnancy. *See Casey*, 505 U.S. at 847. This right authorizes a pregnant woman to seek the means to terminate her pregnancy without State interference that unduly burdens her decision. *See id.* at 876-77. What are the outer boundaries of this right? Certainly, they do not extend beyond the maternal body. A woman seeking an abortion could not claim that this right authorizes killing a child who survives an abortion procedure and is born alive.

Partial-birth abortion bans build upon this understanding of the abortion liberty. The bans acknowledge that pregnancy may be terminated under this Court's precedent, but deny that

it may be terminated in a manner that purposefully seeks to kill the child once the child has begun the process of birth, a process marked by the passage of the living child's body from womb into birth canal to outside the woman's body. At this point, any claim of a right to terminate pregnancy is substantially obviated as pregnancy is terminated. The power and dominion of the abortion liberty diminish as its purpose is achieved and the child is delivered. Since the right to abortion does not include an independent right to assure fetal death, the abortion liberty cannot be asserted to justify a separate act to kill the child as the child proceeds out of the maternal body.

In sum, just as a State's interest in protecting the child increases as the child proceeds toward birth, the woman's right to abortion diminishes as the child leaves the maternal body. Partial-birth abortion bans implement this understanding and further the government's compelling interest in protecting the lives of partially-born children.

Moreover, PBA bans do not impose an undue burden on women seeking abortions because the PBA procedure is never medically indicated; a PBA ban leaves in place conventional abortion procedures; and PBA bans promote the important state interest in protecting maternal health. "After a trial, the district court in the Wisconsin case concluded that the intact D&X procedure is never necessary from the perspective of the patient's health." *Hope Clinic v. Ryan*, 195 F.3d 857, 872 (7th Cir. 1999) (citing *Doyle*, 44 F. Supp. 2d at 979-82). As the AMA declared, PBA is "not medically indicated" and "not good medicine." Letter from P. John Seward, M.D., Executive Vice President, American Medical Association, to U.S. Sen. Rick Santorum (May 19, 1997). Even the American College of Obstetricians and Gynecologists could not identify a situation in which PBA would be the only medically appropriate option.

See Hope Clinic, 195 F.3d at 872. The Seventh Circuit declared that "[w]e proceed on the assumption, which appears to be shared by the American Medical Association, that the D&X is not the best or safest option in any articulable category of situations." *Id.*

This has also been the conclusion of those supporting a federal PBA in Congress. In a 1995 report by the House Committee on the Judiciary, the legal analysis was stated as follows:

> After viability, the government under both *Roe* and *Casey* may prohibit all abortion, except those that are necessary to save the life or health of the mother. Therefore, the government can clearly prohibit partial-birth abortion, a method of abortion preferred by only a handful of abortionists [footnote omitted] that is particularly offensive to humanity. H.R. 1833 leaves alternative procedures, including other methods of abortion, available for a physician to use in a case where a mother's life or health is threatened by bringing her child to term.
>
> Before viability, *Casey* allows regulation of abortion that is reasonably related to a legitimate state interest, unless the regulation places an "undue burden" on a woman's right to choose to have an abortion. [footnote omitted]
>
> The [Act] does not place a "substantial obstacle" in the path of a mother seeking to abort her child. The Act prohibits only abortions in which the child is partially delivered alive and then killed. It does not prohibit alternative, and, in fact, more frequently used late-term abortion techniques. Partial-birth abortions are not performed due to any special circumstances of a mother or her pregnancy.

The procedure is used by a handful of abortionists who "routinely" perform the procedure in late pregnancy. [footnote omitted]

Banning this particularly heinous procedure does not place an "undue burden" on a mother's right to choose to have an abortion. Since [the Act] does not impose an "undue burden," rational basis scrutiny is applied to determine whether [the Act] is constitutional.

. . . .

[The Act] serves several legitimate governmental interests some of which are mentioned above. Among the important interests served by banning partial-birth abortion is the government's interest in protecting human life. During a partial-birth abortion a child is killed after she is partially delivered from her mother's womb. The difference between partial-birth abortion and infanticide is a mere three inches. The [Act] would protect children from being killed in the delivery process.

The Act also serves the interest of protecting the dignity of human life. . . . Allowing an abortionist to kill a child in this manner reduces society's respect for human life.

An additional legitimate interest is the prevention of both moral and legal confusion about the role of physicians in our society. . . . In a partial-birth procedure, the child's life is taken during a breach delivery. A procedure which obstetricians use in some circumstances to bring a healthy child into the world is perverted to result in a dead child. The physician, traditionally trained to do everything in his power to assist and protect both mother and child during the birth process deliberately kills the child in the

birth canal. A doctor holding a child in the palm of his hand and deliberately killing that child offends society's concept of the role of a physician. The [Act] would put an end to this heinous act.

The prevention of cruel and inhumane treatment is another interest furthered by the [Act]. . . .

[The Act] is reasonably related to these and other legitimate government interests[, which become cognizable because of the change in the child' location]. The [Act] is constitutionally permissible and morally imperative.

Partial-Birth Abortion Ban Act of 1995, H.R. Rep. No. 104-267, at 9 (Sep. 27, 1995).

CONCLUSION

Amici Curiae request this Court to reverse the decision of the Eighth Circuit and uphold the constitutionality of the Nebraska partial-birth abortion ban.

Respectfully submitted,

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APPENDICES

A. Dr. Martin Haskell's Monograph

From *Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 Before the Sen. Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 105th Cong. 56 (1997).

B. Partial-Birth Abortion Drawing

From *The Partial-Birth Abortion Ban Act of 1995: Hearing on H.R. 1833 Before the Senate Comm. on the Judiciary*, 104th Cong. 3 (Nov. 17, 1995).

App. 1

Second Trimester Abortion:
From Every Angle
Fall Risk Management Seminar
September 13-14, 1992
Dallas, Texas

Pesentations, Bibliography & Related Materials

[NATIONAL ABORTION FEDERATION LOGO] 1992

Dilation and Extraction for Late Second Trimester Abortion

Martin Haskell, M.D.

Presented at the National Abortion Federation
Risk Management Seminar, September 13, 1992

INTRODUCTION

The surgical method described in this paper differs from classic D&E in that it does not rely upon dismemberment to remove the fetus. Nor are inductions or infusions used to expel the intact fetus.

Rather, the surgeon grasps and removes a nearly intact fetus through an adequately dilated cervix. The author has coined the term *Dilation and extraction or D&X* to distinguish is from dismemberment-type D&E's.

This procedure can be performed in a properly equipped physician's office under local anesthesia. It can be used successfully in patients 20-26 weeks in pregnancy.

The author has performed over 700 of these procedures with a low rate of complications.

BACKGROUND

D&E evolved as an alternative to induction or instillation methods for second trimester abortion in the mid 1970's. This happened in part because of lack of hospital facilities allowing second trimester abortions in some geographic areas, in part because surgeons needed a "right now" solution to complete suction abortions inadvertently started in the second trimester and in part to provide a means of early second trimester abortion to avoid necessary delays for instillation methods.[1] The North Carolina Conference in 1978 established D&E as the preferred method for early second trimester abortions in the U.S.[2,3,4]

Classic D&E is accomplished by dismembering the fetus inside the uterus with instruments and removing the pieces through an adequately dilated cervix.[5]

However, most surgeons find dismemberment at twenty weeks and beyond to be difficult due to the toughness of fetal tissues at this stage of development. Consequently, most late second trimester abortions are performed by an induction method.[6,7,8]

Two techniques of late second trimester D&E's have been described at previous NAF meetings. The first relies on sterile urea intra-amniotic infusion to cause fetal demise and lysis (or softening) of fetal tissues prior to surgery.[9]

The second technique is to rupture the membranes 24 hours prior to surgery and cut the umbilical cord. Fetal death and ensuing autolysis soften the tissues. There are attendant risks of infection with this method.

In summary, approaches to late second trimester D&E's rely upon some means to induce early fetal demise to soften the fetal tissues making dismemberment easier.

PATIENT SELECTION

The author routinely performs this procedure on all patients 20 through 24 weeks LMP with certain exceptions. The author performs the procedure on selected patients 25 through 26 weeks LMP.

The author refers for induction patients falling into the following categories:

Previous C-section over 22 weeks
Obese patients (more than 20 pounds over large frame ideal weight)
Twin pregnancy over 21 weeks
Patients 26 weeks and over

DESCRIPTION OF DILATION AND EXTRACTION METHOD

Dilation and extraction takes place over three days. In a nutshell, D&X can be described as follows:

Dilation
MORE DILATION
Real-time ultrasound visualization
Version (as needed)
Intact extraction
Fetal skull decompression
Removal
Clean-up
Recovery

Day 1 – Dilation

The patient is evaluated with an ultrasound, hemoglobin and Rh. Hadlock scales are used to interpret all ultrasound measurements.

In the operating room, the cervix is prepped, anesthetized and dilated to 9-11 mm. Five, six or seven large Dilapan hydroscopic dilators are placed in the cervix. The patient goes home or to a motel overnight.

Day 2 – More Dilation

The patient returns to the operating room where the previous day's Dilapan are removed. The cervix is scrubbed and anesthetized. Between 15 and 25 Dilapan are placed in the cervical canal. The patient returns home or to a motel overnight.

Day 3 – The Operation

The patient returns to the operating room where the previous day's Dilapan are removed. The surgical assistant administers 10 IU Pitocin intramuscularly. The cervix is scrubbed, anesthetized and grasped with a tanaculum. The membranes are ruptured, if they are not already.

The surgical assistant places an ultrasound probe on the patient's abdomen and scans the fetus, locating the lower extremities. This scan provides the surgeon information about the orientation of the fetus and approximate location of the lower extremities. The tranducer is then held in position over the lower extremities.

The surgeon introduces a large grasping forcep, such as Bierer or Hern, through the vaginal and cervical canals into the corpus of the uterus. Based upon his knowledge of fetal orientation, he moves the tip of the instrument carefully towards the fetal lower extremities. When the instrument appears on the sonogram screen, the surgeon is able to open and close its jaws to firmly and reliably grasp a lower extremity. The surgeon then applies firm traction to the instrument causing a version of the fetus (if necessary) and pulls the extremity into the vagina.

By observing the movement of the lower extremity and version of the fetus on the ultrasound screen, the surgeon is assured that his instrument has not inappropriately grasped a maternal structure.

With a lower extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities.

The skull lodges at the internal cervical os. Usually there is not enough dilation for it to pass through. The fetus is oriented dorsum or spine up.

At this point, the right-handed surgeon slides the fingers of the left had [sic] along the back of the fetus and "hooks" the shoulders of the fetus with the index and ring fingers (palm down). Next he slides the tip of the middle finger along the spine towards the skull while applying traction to the shoulders and lower extremities. The middle finger lifts and pushes the anterior cervical lip out of the way.

While maintaining this tension, lifting the cervix and applying traction to the shoulders with the fingers of the

left hand, the surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger.

Reassessing proper placement of the closed scissors tip and safe elevation of the cervix, the surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening.

The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies traction to the fetus, removing it completely from the patient.

The surgeon finally removes the placenta with forceps and scrapes the uterine walls with a large Evans and a 14 mm suction curette. The procedure ends.

Recovery

Patients are observed a minimum of 2 hours following surgery. A pad check and vital signs are performed every 30 minutes. Patients with minimal bleeding after 30 minutes are encouraged to walk about the building or outside between checks.

Intravenous fluids, pitocin and antibiotics are available for the exceptional times they are needed.

ANESTHESIA

Lidocaine 1% with epinephrine administered *intra*-cervically is the standard anesthesia. Nitrous-oxide/oxygen analgesia is administered nasally as an adjunct. For the Dilapan insert and Dilapan change, 12cc's is used in 3 equidistant locations around the cervix. For the surgery, 24cc's is used at 6 equidistant spots.

Carbocaine 1% is substituted for lidocaine for patients who expressed lidocaine sensitivity.

MEDICATIONS

All patients not allergic to tetracycline analogues receive doxycycline 200 mgm by mouth daily for 3 days beginning Day 1.

Patients with *any* history of gonorrhea, chlamydia or pelvic inflammatory disease receive additional doxycycline, 100mgm by mouth twice daily for six additional days.

Patients allergic to tetracyclines are not given proplylactic [sic] antibiotics.

Ergotrate 0.2 mgm by mouth four times daily for three days is dispensed to each patient.

Pitocin 10 IU intramuscularly is administered upon removal of the Dilapan on Day 3.

Rhogam intramuscularly is provided to all Rh negative patients on Day 3.

Ibuprofen orally is provided liberally at a rate of 100 mgm per hour from Day 1 onward.

Patients with severe cramps with Dilapan dilation are provided Phenergan 25 mgm suppositories rectally every 4 hours as needed.

Rare patients require Synalogos DC in order to sleep during Dilapan dilation.

Patients with a hemoglobin less than 10 g/dl prior to surgery receive packed red blood cell transfusions.

FOLLOW-UP

All patients are given a 24 hour physician's number to call in case of a problem or concern.

At least three attempts to contact each patient by phone one week after surgery are made by the office staff.

All patients are asked to return for check-up three weeks following their surgery.

THIRD TRIMESTER

The author is aware of one other surgeon who uses a conceptually similar technique. He adds additional changes of Dilapan and/or lamineria in the 48 hour dilation period. Coupled with other refinements and a slower operating time, he performs these procedures up to 32 weeks or more.[10]

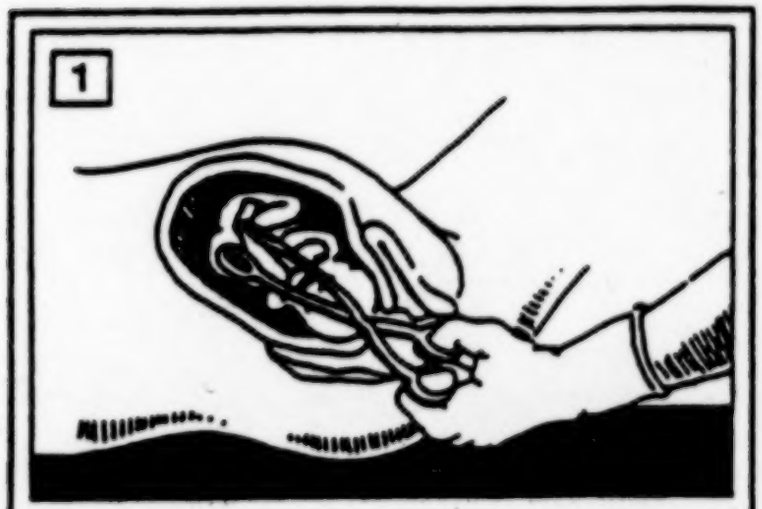
SUMMARY

In conclusion, Dilation and Extraction is an alternative method for achieving late second trimester abortions to 26 weeks. It can be used in the third trimester.

Among its advantages are that it is a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia.

Among its disadvantages are that it requires a high degree of surgical skill, and may not be appropriate for a few patients.

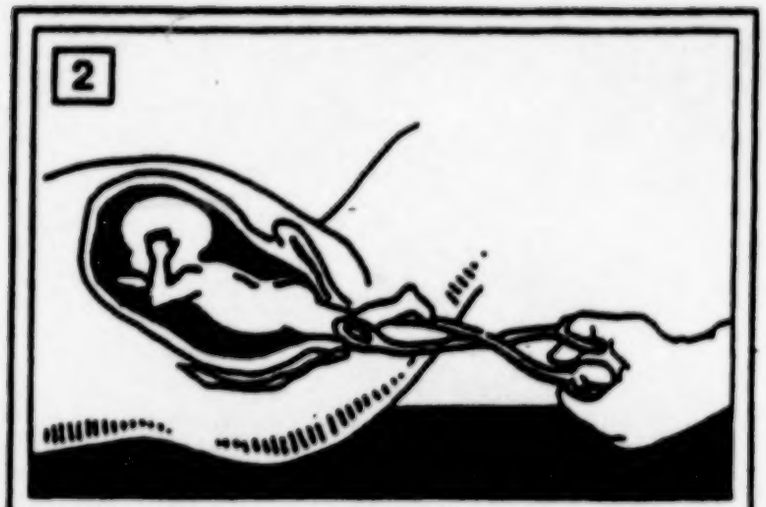
PARTIAL-BIRTH ABORTION



Guided by ultrasound, the abortionist grabs the baby's leg with forceps.

Appendix B

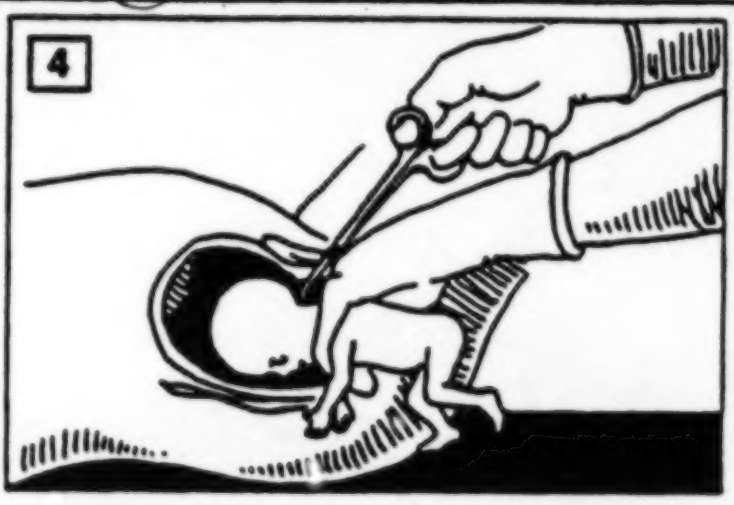
From *Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 Before the Sen. Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 105th Cong. 56 (1997).



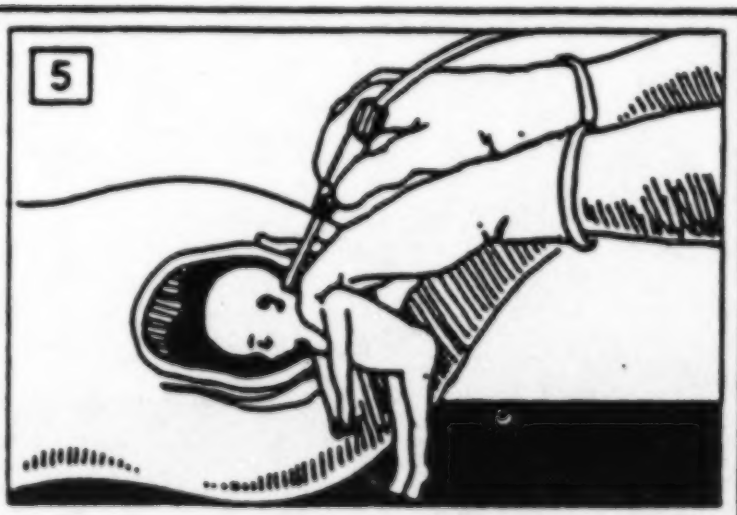
The baby's leg is pulled out into the birth canal.

The abortionist delivers the baby's entire body, except for the head.

27



The abortionist jams scissors into the baby's skull. The scissors are then opened to enlarge the hole.



The scissors are removed and a suction catheter is inserted. The child's brains are sucked out, causing the skull to collapse. The dead baby is then removed.

Feb 28 2000

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No. 99-830

Supreme Court, U.S.
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IN THE
Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, GINA DUNNING, Director of Regulation and Licensure of the Nebraska Department of Health and Human Services, and CHARLES ANDREWS, M.D., Chief Medical Officer of the State of Nebraska,

Petitioners,

v.

LEROY H. CARHART, M.D.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF *AMICUS CURIAE* OF THE KNIGHTS OF COLUMBUS IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICUS CURIAE*

The Knights of Columbus submits this brief *amicus curiae* in support of the petitioners.[1]

The Knights of Columbus is a charitable Catholic family fraternal organization of over 1.6 million members and their families, totaling approximately six million people. Founded in New Haven, Connecticut, in 1882 by Father Michael J. McGivney, the Knights of Columbus has grown into an international organization with nearly 12,000 local councils in all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, Canada, Mexico, the Philippines and other countries. The Knights of Columbus is the largest lay organization in the Catholic Church. The law before the Court in this case is from Nebraska, where there are currently nearly 20,000 Knights of Columbus families.

Since its founding, the Knights of Columbus has been dedicated to several purposes, including (1) rendering aid and assistance to its sick, needy and disabled members and their families; (2) promoting social and intellectual discourse among its members and their families; (3) promoting and conducting educational, charitable, religious, social welfare, war relief and public relief work; and (4) maintaining a life insurance program for the benefit of its members, their beneficiaries and their families. Last year alone, the Knights contributed more than $110 million to charitable causes and provided roughly 55 million hours of volunteer service.

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1. Letters of consent to the filing of this brief have been filed with the Clerk of the Court. *See* Sup. Ct. R. 37. Counsel for *amicus curiae* Knights of Columbus wrote this entire brief. No person or entity other than *amicus* made any monetary contribution to the preparation of this brief.

The Knights of Columbus has a long history of advocacy in this Court in cases involving religious liberty, church-state relations, the family, education, parental rights, and other issues. For example, the Knights underwrote the litigation in *Pierce v. Society of Sisters*, 268 U.S. 510 (1925), the landmark case in which this Court safeguarded the fundamental right of parents to direct the education of their children.

In addition, the Knights of Columbus has been a longstanding and consistent advocate of Life before this Court. We support the Right to Life of all human beings from the moment of conception until natural death. To this end, the Knights of Columbus has filed briefs in this Court in virtually every major case dealing with the issue of abortion, including *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992); *Rust v. Sullivan*, 500 U.S. 173 (1991); *Ohio v. Akron Center for Reproductive Health*, 497 U.S. 502 (1990); and *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989). The Knights of Columbus remains committed to the ultimate reversal of *Roe v. Wade*.

Today, this Court is facing the issue of whether a state may outlaw the infanticide known as "partial-birth abortion." Our history, our respect for the Constitution, and our patriotism compel us once again to raise our voices in this Court in an effort to vindicate the rights of free people through the democratic process to protect the lives of children and to outlaw partial-birth abortion.

SUMMARY OF ARGUMENT

There is no constitutional right to kill a child during a live birth. During a partial-birth abortion, the abortionist delivers the baby alive into the birth canal, and then brutally kills the child. Partial-birth abortion, then, is not the "termination of pregnancy," but is the killing of a human child during an already-occurring live birth. The people of Nebraska have properly, and constitutionally, outlawed this barbaric practice.

Roe v. Wade, 410 U.S. 113 (1972), and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), do not drive the result here because those cases did not establish and do not support the creation of a right to kill an infant during birth. Rather, *Roe* and *Casey* created the right to terminate "pregnancy," not "childbirth." *Casey* also vindicated the state's interest in protecting the lives of unborn children throughout pregnancy; in regulating pre-viability abortions so long as such laws do not create an "undue burden;" and in proscribing all post-viability abortions except when necessary to preserve the life or health of the mother. But neither *Roe* nor *Casey* can be read as creating a right to terminate a live birth, and therefore are not applicable to Nebraska's Partial-Birth Abortion Act.

The Court should not create a nontextual constitutional right to terminate childbirth by expanding the right created in *Roe* and *Casey* to give it effect during birth as well as pregnancy. By doing so, the Court would be establishing a new constitutional right that would have no defensible legal or logical boundaries. Indeed, this would be tantamount to creating a right to infanticide. The crime of infanticide should not be enshrined as a fundamental right. But the reasoning

employed in striking down Nebraska's partial-birth abortion law would immediately or ultimately do just that.

Because there is no right to terminate a live birth, this Court should reverse the Eighth Circuit's holding in *Carhart v. Stenberg*, 192 F.3d 142 (8th Cir. 1999), and give effect to Nebraska's law banning partial-birth abortion.

STATEMENT OF THE CASE

The Knights of Columbus adopts the Statement of the Case set forth in the brief of Petitioners, Don Stenberg, Attorney General of the State of Nebraska, et al. However, the basic facts concerning the partial-birth abortion procedure are undisputed. In fact, the grim business of partial-birth abortion is almost defiantly described in all of its frightening detail in the brief submitted on behalf of respondent Carhart: "In such a procedure, he draws the fetus out of the uterus up to the head and then compresses the fetal head either by crushing it or by removing the cranial contents using suction." (*See* Respondent's Brief in Opposition to the Writ of Certiorari at 4.) Respondent unabashedly admits that he "deliberately and intentionally deliver[s] into the vagina a living unborn child, or substantial portion thereof;" and does so " 'for the purpose of performing a procedure' he 'knows will kill the unborn child and does kill the unborn child.' " *Id.*

One experienced registered nurse describes the procedure, absent euphemisms, as follows:

> I stood at the doctor's side and watched him perform a partial-birth abortion on a woman who was six months pregnant. The baby's heartbeat

> was clearly visible on the ultrasound screen. The doctor delivered the baby's body and arms, everything but his little head. The baby's body was moving. His little fingers were clasping together. He was kicking his feet. The doctor took a pair of scissors and inserted them into the back of the baby's head, and the baby's arms jerked out in a flinch, a startle reaction, like a baby does when he thinks that he might fall. Then the doctor opened the scissors up. Then he stuck the high-powered suction tube into the hole and sucked the baby's brains out. Now the baby was completely limp. Next [the doctor] delivered the baby's head. He cut the umbilical cord and delivered the placenta. He threw the baby in a pan, along with the placenta and the instruments he had just used. I saw the baby move in the pan. . . . I never went back to the clinic. But I am still haunted by the face of that little boy. It was the most perfect, angelic face I have ever seen.[2]

Nebraska, along with numerous other states, has outlawed partial-birth abortion.

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2. Statement of Brenda Pratt Shafer before the Subcommittee on the Constitution, Committee on the Judiciary, U.S. House of Representatives, March 21, 1996, concerning a partial-birth abortion she witnessed after being assigned to an abortion clinic by her nursing agency.

ARGUMENT

I. THERE IS NO CONSTITUTIONAL RIGHT TO KILL A CHILD DURING CHILDBIRTH.

There is no constitutional right to kill a child in the process of birth, whether or not that child has emerged fully from the birth canal. Because no right to terminate birth exists, Nebraska's clearly drafted statute proscribing a procedure that results in the killing of a child in the process of being born alive is fully consistent with the U.S. Constitution. As set forth below, neither *Roe* nor *Casey* can be said to include, or provide the basis for creating, a "right to terminate birth." Those cases concerned only the right to "terminate pregnancy."[3] Indeed, *Casey* limited and sought to define the boundaries of the right created in *Roe*, and cannot provide the basis for an unprecedented metamorphosis of that "right" into a license to kill children during childbirth.

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3. *See, e.g., Roe v. Wade*, 410 U.S. 113, 153 ("This right to privacy . . . is broad enough to encompass a woman's decision whether or not to terminate pregnancy."); *Planned Parenthood v. Danforth*, 482 U.S. 52, 60 (1976) (*Roe v. Wade* established a constitutional right to "terminate pregnancy."); *Planned Parenthood v. Casey*, 505 U.S. 833 ("[I]t is a Constitutional liberty of the woman to have some freedom to terminate her pregnancy."; and "The woman's right to terminate her pregnancy before viability is the most central principle of *Roe v. Wade*."). Further, *Roe* and *Casey* both affirm that, after viability, "the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions." *Casey*, 505 U.S. at 835-36; *see also Roe v. Wade*, 410 U.S. 113, 163-64 ("State regulation protective of fetal life after viability thus has both logical and biological justifications. If the state is interested in protecting fetal life after viability, it may go so far as to proscribe abortions during that period, except when it is necessary to preserve the life or health of the mother.").

A. *Roe* and *Casey* Do Not Establish or Support a Right to Terminate a Live Birth.

Here, respondent seeks a constitutional right to terminate a live birth. But he can find no solace in *Roe* or *Casey*. Whatever those cases mean, nothing in them suggests that the Constitution contains a nontextual right to terminate birth once it has begun. Such a new "right" was never contemplated by *Roe* or *Casey* and, in fact, would directly contradict the language and reasoning in those cases. By their express terms, *Roe, Casey,* and every other abortion case decided by this Court concerned the "right to terminate *pregnancy*." "Pregnancy" is "the condition resulting from the fertilized ovum. The existing of the condition beginning at the moment of conception and terminating with the delivery of the child."[4] In stark contrast, "partial-birth abortion" involves inducing childbirth and then killing the living child during the birth process, in the birth canal. Logic establishes what medicine confirms: once birth begins, pregnancy is over.

That the *Roe* Court never contemplated extending a woman's "right to terminate pregnancy" out of the womb and into the birth canal is clearly evident in the opinion itself. The *Roe* majority noted that the Texas law criminalizing the killing of a child in the birth canal during the process of childbirth was not even being challenged in the case. Specifically, the Court recognized that Article 1195 of the Texas Penal Code provided and still provides that "Whosoever shall during parturition of the mother destroy the vitality or life in a child *in a state of being born and before actual birth*, which child would otherwise have been

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4. *Black's Law Dictionary*, 1179 (6th ed. 1990).

born alive, shall be confined to the penitentiary for life or for not less than five years." *Roe*, 410 U.S. 113, 118, n.1 (emphasis added). Surely the *Roe* Court could not have let stand a law punishing with life imprisonment an act which the Court thought to be a fundamental right protected by the Constitution. Nor would the Court have noted the existence of the law without any adverse comment if it felt the law contravened the newly-born privacy right discovered in *Roe* itself.

B. *Casey* Limited, And Did Not Expand, the "Right To Terminate Pregnancy" Discovered in *Roe*, And Affirmed the State's Interest In Protecting Human Life.

In *Casey*, this Court, *if anything*, sought to place limits on — and not expand — *Roe*'s reasoning. In fact, *Casey* expressly overruled such post-*Roe* cases as *Thornburgh*[5] and *Akron I*[6] that read *Roe* too broadly, thereby unreasonably limiting a State's ability to protect unborn children through legitimate laws restricting abortion.[7] *Casey* further held that the state has a "profound interest" in protecting the lives of unborn children "throughout pregnancy." *Casey*, 505 U.S. at 878.[8]

5. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986).

6. *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983).

7. *See Casey* 505 U.S. at 870 ("[W]e must overrule those parts of *Thornburgh* and *Akron I* which, in our view, are inconsistent with *Roe*'s statement that the State has a legitimate interest in promoting the life or potential life of the unborn.").

8. *Casey*, 505 U.S. at 871 ("Yet it must be remembered that *Roe v. Wade* speaks with clarity in establishing not only the woman's liberty but also the State's 'important and legitimate interest in potential life.' . . . That portion of the decision in *Roe* has been given too little acknowledgment and implementation by the Court in its subsequent cases.").

Rather than expand *Roe*, *Casey* redefined its holding to ensure that the State's interest in protecting human life was respected. *Casey* rejected *Roe*'s rigid trimester system precisely because of this "basic flaw in the trimester framework: even in *Roe*'s terms, in practice it undervalues the State's interest in the potential life within the woman." *Casey*, 505 U.S. at 875. Ultimately, *Casey* held that, prior to viability, abortion may be regulated as long as state laws do not pose an "undue burden" to a woman seeking to terminate pregnancy.[9] After viability, the "undue burden" standard no longer applies, and a state may proscribe all abortion, except where it is necessary for the preservation of the life or health of the mother. *Casey*, 505 U.S. at 878. The Court stated in *Casey* that

> viability, as we noted in *Roe*, is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman.

Casey, 505 U.S. at 870.

Therefore, even the right "to terminate pregnancy" announced in *Roe* and redefined in *Casey* is not absolute, and is subject to significant restriction by the people acting

9. Further, the Court noted that "[t]he very notion that the state has a substantial interest in potential life leads to the conclusion that not all regulations must be deemed unwarranted. Not all burdens on the right to decide whether to terminate a pregnancy will be undue." *Casey*, 505 U.S. at 876.

through their legislatures to enact laws protecting the lives of unborn children.[10] *Roe* and *Casey*, then, directly contradict any attempt to create a new privacy right to "terminate childbirth" by reference to or reliance on the "right to terminate pregnancy" created in *Roe*.

C. Even Under a *Roe* and *Casey* Analysis, the Nebraska Act is Constitutional.

As stated, *Roe* and *Casey* do not apply here by their own terms. But the Nebraska Partial-Birth Abortion Act, properly read, is constitutional even under a *Roe-Casey* analysis. The law plainly does not contravene either the "undue burden" test, which applies only to pre-viable fetuses,[11] or *Casey*'s post-viability "health" exception.

> Central to this legal conclusion is the fact, accepted by the American Medical Association, that "[partial-birth abortion] is not the best or safest option in any articulable category of

10. *See, e.g.*, *Casey*, 505 U.S. at 887 ("Even the broadest reading of *Roe*, however, has not suggested that there is a constitutional right to abortion on demand."); *Roe*, 410 U.S. 113, 153 ("[A]ppellant and some amici argue that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses. With this we do not agree.").

11. Neither should any expansive reading of the "undue burden" test of Casey be accepted to strike down Nebraska's law. Under the "undue burden" test, states have significant room to regulate abortions, and "[t]he fact that a law which serves a valid purpose . . . has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Casey*, 505 U.S. at 874.

> situations." The AMA's Policy H-5.982 concludes, among other things, that "there does not appear to be any identified situation in which [partial-birth abortion] is the only appropriate procedure."

Hope Clinic v. Ryan, 195 F.3d 857, 872 (7th Cir. 1999). The AMA Board of Trustees also stated, with the endorsement of the entire AMA House of Delegates, that partial-birth abortion "is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development." *Women's Medical Professional Corporation v. Voinovich*, 130 F.3d 187, 214 (1997) (Boggs, J., dissenting), citing 40 American Medical News, No. 25 (July 7, 1997).[12]

A contrary interpretation of the *Roe-Casey* "health" exception would swallow the rule. The problem, as everyone knows, arises over the meaning of the word "health." Can it mean that after viability a state can proscribe abortions except for those that an abortionist is willing to deem "medically necessary?" Some have argued that every abortion is "medically necessary," because the woman seeking it can claim to be harmed in some way, at least emotionally or psychologically, if she is denied.

Yet if "health" can mean anything, then *Casey* means nothing. "A constitutionally based health exception for every procedure, coupled with a prohibition against review of physicians' beliefs about which procedures are safest, would

12. *See also* American Medical Association letter to U.S. Senator Rick Santorum, May 19, 1997, supporting the federal Partial-Birth Abortion Ban Act of 1997 ("Thank you for the opportunity to work with you towards restricting a procedure we all agree is not good medicine.").

amount to a rule that anything goes." *Hope Clinic v. Ryan*, F.3d at 874. But this would mean that there is no right as vigorous as a nontextual one, expanding as needed and constituting only a "verbal shell game" used to "conceal raw judicial policy choices concerning what is 'appropriate' abortion legislation." *Casey,* 505 U.S. at 833 (Scalia, J., dissenting).

II. CREATION OF A NEW RIGHT TO TERMINATE CHILDBIRTH COULD NOT BE CONSTRAINED AND WOULD CONSTITUTIONALIZE INFANTICIDE.

This Court has repeatedly reaffirmed that states have an "unqualified interest in the preservation of human life." *See Washington v. Glucksberg*, 512 U.S. 702, 728 (1997). In *Glucksberg* the Court refused to recognize a privacy right to commit suicide with the help of a doctor, and also held that the "viability" of life has no bearing on the state's interest in protecting it. *Id.* at 728. The Constitution simply does not create an unenumerated right to terminate non-viable human life.

Proponents of a constitutional right to assisted suicide had argued that a state's interest in preserving life extends only to "those who can still contribute to society and enjoy life." *Id.* at 729. The Court rejected this disturbing reasoning, and vindicated the right of the citizens to enact a law that "insists that all persons' lives, from beginning to end, regardless of physical or mental condition, are under the full protection of the law." *Id.* at 729.[13]

13. *Glucksberg* also recognized two other valid state interests that are directly implicated here: (1) the "interest in protecting vulnerable groups;" and (2) the interest in preventing acts that "undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming." *Glucksberg*, 521 U.S. at 731.

Glucksberg also forcefully made the point that there could be no constitutional right to physician assisted suicide precisely because such a right could not be contained. The Court held that a constitutional purpose for outlawing physician assisted suicide was that "the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia." *Glucksberg* at 732. States, therefore, have a legitimate interest in preventing the slippery slope into euthanasia by recognizing that physician assisted suicide can swiftly become physician assisted homicide. Put another way, one reason a new constitutional right to suicide could not be recognized was precisely because such a discovered, non-textual right would have no obvious, defensible limits. *Id.* at 733 ("Thus, it turns out that what is couched as a limited right to 'physician assisted suicide' is likely, in effect, a much broader license, which could prove extremely difficult to police and constrain.").[14] This holding applies here *a fortiori*.

If the Court concludes in this case, explicitly or implicitly, that the Constitution creates a right to kill a living child during birth, there will be no way to define or control that so-called right, because there is no way to distinguish that act from infanticide. In fact, the reasoning used to establish such a right would support legal infanticide even after birth. This certainly cannot be said to have been intended by *Roe* and *Casey*. But this is precisely what will result. *See Glucksberg*, 521 U.S. 702, 735, quoting, *United States v. 12 200-ft Reels of Super 8mm Film*, 413 U.S. 123, 127, 93 S. Ct. 2665, 2668 (1973) ("Each step, when taken,

14. "The case for the slippery slope is fairly made out here . . . because there is a plausible case that the right claimed would not be readily containable. . . ." *Glucksberg*, 521 U.S. at 785 (Souter, J., concurring).

appears a reasonable step in relation to that which preceded it, although the aggregate or end result is one that would never have been seriously considered in the first instance.").

While "[l]iberty must not be extinguished for want of a line that is clear," *Casey*, 505 U.S. at 869, neither must innocent human life. Here, the child has been removed from the womb alive, and it is literally only a few inches from being out of the birth canal entirely. How can it be said that the Constitution forbids the citizens of a state from enacting laws which prohibit the killing of this child? Today, the Court must draw the line, at the very least, at the beginning of childbirth. That is a province where *Roe* and *Casey* must not have any effect. There is simply no right to remove a child alive, or begin removing a child alive, and then kill her.

If the Court has any doubt that creating this new right would be tantamount to constitutionalizing infanticide, then it need only survey some of the most recent literature. For example:

- Princeton University Professor Peter Singer argues explicitly that birth is no barrier to killing infants. According to Dr. Singer, "[I]f the fetus does not have the same claim to life as a person, it appears that the newborn baby does not either, and the life of the newborn baby is of less value than the life of a pig, a dog, or a chimpanzee." Peter Singer, *Practical Ethics*, 122-23 (Cambridge University Press, 1979). Singer concludes that there should be some period *after* live birth for parents to decide whether to kill their infant children.

- Singer warns that "in thinking about [infanticide] we should put aside feelings based on the small, helpless and — sometimes — cute appearance of human infants. . . . Nor can the helplessness or innocence of the infant *homo sapiens* be a ground for preferring it to the equally helpless and innocent fetal *homo sapiens*, or, for that matter, to laboratory rats who are 'innocent' in exactly the same sense as the human infant." *Id.* at 123-24.

- Singer concludes: "[I]f we can put aside these emotionally moving but strictly irrelevant aspects of the killing of a baby we can see that grounds for not killing persons do not apply to newborn infants." *Id.* at 124.

And Singer is by no means alone:

- Nobel laureates James Watson and Francis Crick, the discoverers of the structure of DNA, have supported a general right to infanticide. Watson has stated that children should not be "declared alive until three days after birth" so that parents may choose to kill their newborn child. *See* David Cannon, *Abortion And Infanticide: Is There a Difference?, Policy Review*, 1985 Spring, 12 (listing numerous examples of advocates of a right to infanticide). For his part, Crick has argued that "no newborn infant should be declared human until it has passed tests regarding its genetic endowment and . . . if it fails these tests, it forfeits the right to life." *Id.*

Examples are plentiful, but the point is made: Many prominent doctors, lawyers, philosophers, and so-called "ethicists" are openly arguing for a right to kill children.

Those who argue for a right to infanticide take two basic approaches, both of which are founded on the concepts of "personhood" or "viability," which are discussed in *Roe* and *Casey*.[15] Proponents of infanticide claim that because the *Roe* Court held that the unborn child is not a legal "person" worthy of protection under the Fourteenth Amendment, and because a born child does not differ in any meaningful way

15. In *Roe*, the Court decided that unborn children are not "persons" worthy of protection under our laws. *Roe*, 410 U.S. 113, 158 ("[T]he word 'person,' as used in the Fourteenth Amendment, does not include the unborn."). And the Court recognized that the entire case hinged on this issue: "If this suggestion of personhood is established, the appellant's case, of course, collapses, for the fetus' right to life would be guaranteed specifically by the Amendment." *Id.* at 156-57. But the Court also held: "We need not resolve the difficult question of when life begins." *Id.* at 159. By this reasoning, the Court rested *Roe*'s foundation on a flawed distinction between human life and legal persons. The current debate over infanticide is, at least in part, the fruit of this distinction. The Court itself noted that unborn children had any number of legal rights, including in tort, property, criminal law, inheritance and other areas. They still do. So, it seems, one can be a plaintiff without being a person. Some legal scholars have noted ironically that one member of the *Roe* Court, shortly before *Roe*, wrote: "The ordinary corporation is a 'person' for purposes of the adjudicatory processes. . . . So it should be as respects valleys, alpine meadows, rivers, lakes, estuaries . . . swampland, or even air. . . ." *Sierra Club v. Morton*, 405 U.S. 727, 742-43, 749 (1972) (Douglas J., dissenting), as quoted in William J. Mitchell, *A Modest Proposal*, 39 Catholic Lawyer, Nos. 2-3, 233, n.18. Justice Douglas soon after voted to reject "the unborn child's rights as an entity or person." *Id.*, citing *Doe v. Bolton*, 410 U.S. 179, 203 (1973) (Douglas J., concurring).

from an unborn child except for its physical location, born children are not legal "persons" either. Nearly all of these commentators admit that the fetus is a "human being," but argue that a child's status as a human being is not enough to vest that child, born or unborn, with the right to life. That is only available to "persons," narrowly and subjectively defined.

Professor Singer puts it this way:

> The pro-life groups were right about one thing: the location of the body inside or outside the womb cannot make such a moral difference. We cannot coherently hold that it is all right to kill a fetus a week before birth, but as soon as the baby is born everything must be done to keep it alive. The solution, however, is not to accept the pro-life view that the fetus is a human being with the same moral status as yours or mine. The solution is the very opposite: to abandon the idea that all human life is of equal worth.[16]

By and large, then, proponents of the right to kill both born and unborn children do not deny the humanity of these children,[17] but cleave a distinction between "human beings" and "persons."

16. David Cannon, *Abortion and Infanticide, Is There A Difference?*, Policy Review, 1985 Spring, quoting Peter Singer. It should be noted with interest that, although Professor Singer believes certain children can and should be killed, he has demonstrated against the mistreatment of chickens. *See* Span, "A Professor's Lively Ideas on Euthanasia," *The Washington Post*, Dec. 9, 1999, C1.

17. Feminist author Naomi Wolf discussed her response to a question concerning her own unborn child as follows: "Had I not been so nauseated and cranky . . . I might not have told what is the truth for me: 'Of course it's a baby.' " *See* Naomi Wolf, "Our Bodies, Our Souls: Rethinking Pro-Choice Rhetoric," *The New Republic*, October 16, 1995.

Under this bizarre logic, only a "person" has a right to life, but human beings who have not achieved this exalted and subjectively defined status may be killed.

The unborn child and now, the born infant, are by this reasoning relegated to the unprecedented status of human beings without basic human rights, the most basic of which is, of course, the right to life. Under this argument, human life has no intrinsic value, and we have no objective reason to protect it. If the parents want the child, then she is a "person" and they implicitly grant her "personhood," one presumes, by failing to kill her. If the parents decide they do not want the child, then they may determine subjectively that she is not a "person," has no rights and, although human, may be killed.

This philosophy was chillingly described in the July 5, 1993 edition of American Medical News by the late Dr. James McMahon, who performed thousands of partial-birth abortions: "After 20 weeks, where it frankly is a child to me, I really agonize over it because the potential is so imminently there. I think, gee, it's too bad that this child couldn't be adopted. On the other hand, I have another position, which I think is superior in the hierarchy of questions, and that is: "Who owns this child? It's got to be the mother." James Bopp, Jr. and Curtis R. Cook, M.D., *Partial Birth Abortion: The Final Frontier of Abortion Jurisprudence*, 14 Issues L. & Med. 3. This subjective determination of the "personhood" of human beings serves as a primary basis to argue for a right to infanticide.

These beliefs — which would have given Herod pause — are now being encouraged in the academy. If the Court holds that the Constitution grants the right to kill children during birth, outside the uterus, then on what basis will

infanticide be opposed? Ironically, Judge Posner's dissent in *Hope Clinic v. Ryan*, 195 F.3d 857 (1999), provides some support for this point. Said Judge Posner: "From the standpoint of the fetus, and, I should think, of any rational person, it makes no difference whether, when the skull is crushed, the fetus is entirely within the uterus or its feet are outside the uterus. . . . [T]here is no meaningful difference between the forbidden and the privileged practice." *Id.* at 879. He concludes simply that "[c]ircumstances conspired, as it were, to produce a set of laws that can fairly be described as irrational." *Id.* at 880.

But this proves too much. If the location of the child cannot logically affect its status or its rights, if the child may be killed either in the womb during pregnancy or in the birth canal during birth, then what prevents the same child from being killed once it is outside the birth canal? Judge Posner declares, *ipse dixit*: "Line drawing is inescapable but the line between feticide and infanticide is birth. Once the baby emerges from the mother's body, no possible concern for the mother's life or health justifies killing the baby." *Id.* at 882. But why? Such a conclusion does not follow from Judge Posner's reasoning. If location of the child during this procedure is irrelevant, and making any distinction based on physical location is "irrational," then why does birth necessarily cut off any supposed parental rights to kill the very same child?

What, for that matter, is meant by the term "birth" in this analysis? When does the child officially qualify as worthy of protection from being killed? When the head emerges from the birth canal? When the torso emerges? When the entire body emerges? When the umbilical cord is cut? Can the child be killed if any part of her body, however small, is still remaining in the birth canal? For that matter, is birth a reversible condition? Can a child who slips from the birth canal be put back in and

killed? Or can a doctor actively prevent "birth," however defined, and hold the child in the birth canal long enough to kill her?

These questions are not academic. They must be considered and answered in this case. And the answers are critical. The most important question is this: If unborn children are not distinguishable from born infants based on their intrinsic characteristics, and if distinctions based on physical location are irrational, then why isn't *greater* and not *less* legal protection for unborn children warranted, or at least for children in the process of being born alive? More to the point, why would the Constitution prevent the people from deciding this issue for themselves?

This Court held in *Casey* that "[c]onsistent with other constitutional norms, legislatures may draw lines which appear arbitrary without the necessity of offering a justification. But courts may not. We must justify the lines we draw." *Casey*, 505 U.S. at 870. The Court should not recognize a constitutional right to kill a child during birth, because such a right cannot be logically distinguished from constitutionalized infanticide. The right created in *Roe* to "terminate pregnancy" must by its very terms end when birth begins. Extending this "right" into the birth process would effectively create a new nontextual right to terminate childbirth. Just as *Roe* and *Casey* would not be confined to pregnancy, neither could such a new right be limited to the birth process. The reasoning used to label as arbitrary any line confining *Roe* to the womb would be precisely the same logic used to argue that confining *Carhart* only to the birth canal is likewise arbitrary. The Court should draw a line in this case confining *Roe* and *Casey* to their established limits, protecting against infanticide, and preserving the rights of citizens to enact laws banning partial-birth abortion.

The Court must establish in this case that the monstrous arguments now being raised in favor of the killing of infants will never have legal effect. These arguments offend our Constitution, and the Court should clearly reject them. The Constitution must not be turned into a death warrant for millions of helpless, innocent children.

While some refer to the victims of partial-birth abortion in this country as the "products of conception," we know they are Americans. Can it be that under our laws a matter of inches separates a fundamental constitutional right from a capital crime? Of course not.

CONCLUSION

There is no constitutional right to terminate live childbirth. The Court should reverse the Eighth Circuit's decision in this case. Nebraska's Partial-Birth Abortion Act is constitutional.

Respectfully submitted,

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In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF AMICUS CURIAE OF VIRGINIA, ALABAMA, IDAHO, ILLINOIS, IOWA, MICHIGAN, NORTH DAKOTA, OHIO, PENNSYLVANIA, SOUTH CAROLINA, SOUTH DAKOTA, UTAH, THE GOVERNOR OF RHODE ISLAND, THE GOVERNOR OF WEST VIRGINIA, AND THE STATE LEGISLATURE OF NEW JERSEY IN SUPPORT OF PETITIONERS

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INTERESTS OF *AMICI CURIAE*

The States of our Union have a deep and abiding interest in preserving the basic constitutional principles on which our people erected their institutions of government. Federalism and the separation of powers are two such principles. Both are implicated whenever a federal court is called upon to judge the constitutionality of a statute enacted by the people of a State. In order to uphold these principles – while fully protecting constitutional liberties – the Supreme Court has declared a cardinal rule: a federal court must not declare a State statute unconstitutional if there is any fair interpretation of the statute by which it can be saved. It is to preserve this rule – and the constitutional principles it embodies – that these States and State officials submit this brief as *amici curiae*.[1]

SUMMARY OF ARGUMENT

From the earliest days of the Republic, this Court has sought the meaning of statutes in light of this broad principle: that legislative acts of the sovereign must be construed, whenever possible, to avoid conflicts with the law to which the sovereign is bound. It is a principle that

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[1] Pursuant to Rule 37.3, counsel for the Petitioners and the Respondent have given written consent to the filing of this *amicus curiae* brief. Copies of the consent letters have been filed with the Clerk.

has been explicated in increasing detail as circumstances warranted. First applied to a potential conflict between federal and international law, the principle was soon expanded to cover federal statutes and the federal constitution. The Court next applied the principle to cover State statutes challenged for alleged constitutional violations and then extended the principle so as to avoid not only manifest unconstitutionality, but also grave doubts about the constitutionality of a statute. Recently, the Court has provided more detailed examples of the analysis that federal courts should follow in trying to save a statute from unconstitutionality.

The mandate of the rule is beyond debate, but not beyond misapplication. In the case at bar, the Eighth Circuit acknowledged the rule, then proceeded to disregard it, striking down Nebraska's ban on partial birth abortions even though that State offered a statutory interpretation that avoided constitutional danger. The court of appeals read the statute to ban conventional abortion procedures. Yet, by Nebraska's reading of its law, only dilation and extraction ("D&X") abortions are prohibited. This Court should accept Nebraska's interpretation of its law, as presented by its Attorney General, and reverse the judgment of the court of appeals.

The Nebraska case is not, however, the only occasion on which federal courts have declared statutes unconstitutional despite the availability of narrowing constructions. Other States have experienced similar treatment of their laws, especially in the area of abortion. The *Amici* urge this Court to restate its cardinal rule in terms so explicit as to admit no possible misunderstanding. Specifically, the *Amici* urge this Court to adopt the following two corollaries:

> **First proposed corollary:** When a federal court construes a State statute that has not been authoritatively construed by the courts of that State, the federal court shall not reject a proffered interpretation that would avoid constitutional problems, unless the interpretation is one that is not susceptible to debate among reasonable jurists.
>
> **Second proposed corollary:** When a federal court construes a State statute that has not been authoritatively construed by the courts of that State, the federal court shall not reject an interpretation advanced by the State, if certification to the State's highest court is available to test the proffered interpretation.

ARGUMENT

THE CARDINAL RULE OF CONSTRUCTION: ITS ORIGIN AND DEVELOPMENT

Stated in its most general terms, the principle at issue in this case is that legislative acts of the sovereign must be construed, whenever possible, to avoid conflicts with the law to which the sovereign is bound. The principle received its first formulation from Chief Justice John Marshall in a case involving international law. "[A]n act of Congress ought never be construed to violate the law of nations if any other possible construction remains." *Murray v. The Charming Betsy*, 6 U.S. 64, 118 (1804). Just as the sovereign is subject to the law of nations, so too are federal and State governments – each sovereign in its own sphere – subject to the Constitution. Thus, the basic principle recognized in the *The Charming Betsy* was soon applied to purely domestic cases. In construing an early federal statute, this Court said, "No court ought, unless the terms of the act rendered it **unavoidable**, to give a construction to it which should involve a violation, however unintentional, of the constitution." *Parsons v. Bedford*, 28 U.S. 433, 448-49 (1830) (emphasis added). Again, in

United States v. Coombs, 37 U.S. 72, 76 (1838), this Court wrote:

> If a section of an act of congress admits of two interpretations, one of which brings it within, and the other presses it beyond the constitutional authority of congress; it is the duty of the Supreme Court to adopt the former construction: because a presumption never ought to be indulged, that congress meant to exercise or usurp any unconstitutional authority; unless that conclusion is forced on the Court, by language **altogether unambiguous**.

(Emphasis added).

It is not only acts of Congress that have the benefit of this rule. The same logic applies to acts of State legislatures, a point firmly imbedded in constitutional jurisprudence well before the end of the 19th century. *Grenada County Supervisors v. Brogden*, 112 U.S. 261 (1884), was a diversity action involving the interpretation of a Mississippi statute in light of limitations imposed by the constitution of that State. Relying on precedent from Mississippi and other States, as well as general constitutional principles, this Court embraced a "duty to adopt that construction which, without doing violence to the fair meaning of the words used, brings the statute into harmony with the provisions of the constitution." *Id.* at 269. Soon thereafter, this Court decided *Presser v. Illinois*, 116 U.S. 252 (1886), a case that turned upon the interpretation of State law in light of federal constitutional limitations. The issue was whether an Illinois statute conflicted with acts of Congress for the organization of the militia. Finding no conflict, this Court said "it is a rule of construction that a statute must be interpreted so as, if possible, to make it consistent with the Constitution and paramount law." *Id.* at 269. What was a "rule of construction" in *Presser* was elevated to an "elementary rule" in

Hooper v. California, 155 U.S. 648, 657 (1895) ("The elementary rule is that every reasonable construction must be resorted to in order to save a statute from unconstitutionality."). And what was an "elementary rule" in *Hooper* was further elevated to a "cardinal rule" in *Knights Templars' & Masons' Life Indem. Co. v. Jarman*, 187 U.S. 197, 205 (1902).

Notwithstanding the preeminence of the rule, the formulation in *Knights Templars* was somewhat less emphatic than in earlier and later decisions by this Court. The Court said that "where the language of an act will bear two interpretations, **equally obvious**, that one which is clearly in accordance with the provisions of the constitution is to be preferred." *Id.* (emphasis added). Standing alone, *Knights Templars* might be read to suggest that a court is to choose a constitutional interpretation over an unconstitutional one only if the former is at least as obvious as the latter. But that would misread the rule. While such "parity" between competing interpretations is a **sufficient** circumstance for the rule to apply, it is not a **necessary** one. Shortly after *Knights Templars*, the Court decided *United States v. Delaware & Hudson Co.*, 213 U.S. 366 (1909), and cited *Knights Templars* as authority for the following formulation:

> It is elementary when the constitutionality of a statute is assailed, if the statute be **reasonably susceptible** of two interpretations, by one of which it would be unconstitutional and by the other valid, it is our plain duty to adopt that construction which will save the statute from constitutional infirmity.

Id. at 407, citing *Knights Templars*, 187 U.S. at 205 (emphasis added).

Thus, in order to merit adoption, the constitutional interpretation need not be "equally obvious" with the unconstitutional one. It need only be an interpretation to

which the statute is "reasonably susceptible." *Delaware & Hudson* also recast the rule in a way that extended it to cases where the unconstitutionality of one interpretation was not definite, but only a matter of grave doubt:

> [T]he rule plainly must mean that where a statute is susceptible of two constructions, by one of which **grave and doubtful** constitutional questions arise and by the other of which such questions are avoided, our duty is to adopt the latter.

Id. at 127 (emphasis added).

This expansion of the rule was underscored in a long line of cases that extended into the early 1930s.[2] In 1932, the Court decided *Crowell v. Benson*, 285 U.S. 22 (1932), a case involving the constitutionality of a federal statute that vested commissioners – rather than federal judges – with the power to make certain decisions about workers' compensation cases. The Court invoked the rule by a formulation that reaffirmed three of its salient features: "even if a **serious doubt** of constitutionality is raised, it is a **cardinal principle** that this Court will first ascertain whether a construction of the statute is **fairly possible** by which the question may be avoided." *Id.* at 62 (emphasis added). By so formulating the rule, the Court implicitly rejected a competing formulation advanced by the dissent, which used the approach suggested by an overly narrow reading of *Knights Templars*. The dissent took issue with the majority's construction, saying that the statute "is not equally susceptible to two constructions." *Id.* at 76. By contrast, the majority asked only whether a saving construction is "fairly possible" and whether the

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[2] *See, e.g., United States v. Jin Fuey Moy*, 241 U.S. 394, 401 (1916); *Bratton v. Chandler*, 260 U.S. 110, 114 (1922); *Blodgett v. Holden*, 275 U.S. 142, 148 (1927); *Lucas v. Alexander*, 279 U.S. 573, 577 (1929).

statute is "open" to such a construction. *Id.* at 62 (majority opinion). This formulation of the rule continued to be invoked by the Court. *See, e.g., International Ass'n of Machinists v. Street*, 367 U.S. 740, 749-50 (1961); *NLRB v. Catholic Bishop*, 440 U.S. 490, 500-01 (1979).

In a series of First Amendment cases beginning in the mid-1970s, the Court used a somewhat different formulation. *Erznoznik v. City of Jacksonville*, 422 U.S. 205 (1975), involved a city ordinance that prohibited showing films containing nudity at a drive-in movie theater when its screen is visible from a public place. The Court was concerned that a "demonstrably overbroad statute or ordinance may deter the legitimate exercise of First Amendment rights." *Id.* at 216. Yet, it also recognized that facial challenges must be approached with "caution and restraint" because "invalidation may result in unnecessary interference with a state regulatory program." *Id.* The Court said that "in accommodating these competing interests the Court has held that a State statute should not be deemed facially invalid unless it is not **readily subject** to a narrowing construction by the state courts. . . ." *Id.* (emphasis added). This formulation suggests three questions. First, in assessing the availability of a constitutional construction, how does the term "readily subject" square with the more familiar term "fairly possible"? Second, assuming *arguendo* that the two terms mean different things, does the newer term displace the old one altogether, or does it have an application limited to First Amendment cases? Third, does use of the term "readily subject" in conjunction with the reference to "state courts" suggest that some different or additional principle may be at work when the statute at issue is one of State, rather than federal law?

Answers to these questions were suggested – though not definitively given – by a trio of cases decided in 1988,

all dealing with the First Amendment. In January of that year, the Court decided *Virginia v. American Booksellers Ass'n*, 484 U.S. 383 (1988), a case involving a State statute that prohibited the display of materials "harmful to juveniles." The Court said:

> It has long been a tenet of **First Amendment law** that in determining a facial challenge to a statute, if it be "**readily susceptible**" to a narrowing construction that would make it constitutional, it will be upheld. *Erznoznik v. City of Jacksonville*, 422 U.S. 205 (1975); *Broadrick v. Oklahoma*, 413 U.S. 601 (1973). The key to application of this principle is that the statute must be "**readily susceptible**" to the limitation; **we will not rewrite** a state law to conform it to constitutional requirements.

Id. at 397 (emphasis added).

On the one hand, this passage suggested that the "readily susceptible" test might apply only in the special context of the First Amendment, and not displace the "fairly possible" test in other contexts. On the other hand, by juxtaposing "readily susceptible" with the extreme alternative of "rewrit[ing] a state law", the Court left open the question of how much more restrictive, if at all, the "readily susceptible" test might be.

The second case to be decided was *Edward J. DeBartolo Corp. v. Florida Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568 (1988). This case did not deal with a State law, but with a federal statute, 29 U.S.C.A. § 158(b)(4)(ii)(B), making it an unfair labor practice for a labor organization to threaten, coerce or restrain any person to cease doing business with another person. The question was whether the statute covered peaceful distribution of certain leaflets at a mall entrance urging customers not to shop there. The National Labor Relations Board had ruled that the federal statute banned such

leafleting; however, in order to avoid "serious questions" of constitutionality, the Court gave it a narrower interpretation that allowed the leafleting to occur. In so doing, the Court did not invoke the phrase "readily susceptible" nor did it cite *Erznoznik* or *American Booksellers*, even though the latter case was decided only four months earlier. Instead, the Court invoked ten other cases stretching from the 1804 decision in *The Charming Betsy* through the 1979 decision in *Catholic Bishop*. In so doing, it presented two formulations of the "cardinal principle," a principle the Court declared "beyond debate." The Court first said: "where an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems **unless such construction is plainly contrary to the intent of Congress.**" 485 U.S. at 575 (emphasis added). Later on the same page, the Court quoted its 1895 decision in *Hooper* for the proposition that "**every reasonable construction** must be resorted to, in order to save a statute from unconstitutionality." 485 U.S. at 575 (emphasis added). By implicitly equating these two formulations of the cardinal rule, *DeBartolo* gave additional meaning to the term "reasonable construction." A proposed construction of a federal statute is reasonable unless it is "plainly contrary to the intent of Congress."

The different approaches in *American Booksellers* and *DeBartolo* appeared to suggest that the "readily susceptible" terminology was not only limited to First Amendment cases, but to First Amendment cases involving State statutes. The same divergent approach was suggested by *Frisby v. Schultz*, 487 U.S. 474 (1988), decided two months after *DeBartolo*. In saving a local ordinance prohibiting residential picketing, the Court reverted back to the terminology used in *Erznoznik* and *American Booksellers*, holding that "the ordinance is **readily subject** to a

narrowing construction that avoids constitutional difficulties." *Id.* at 482 (emphasis added).

Despite the diverging applications suggested in 1988, a 1997 decision gave a unified formulation. In *Reno v. ACLU*, 521 U.S. 844 (1997), the Court considered a First Amendment challenge to portions of the Communications Decency Act ("CDA"), 47 U.S.C.A. §§ 223(a)(1) and (d). This federal statute prohibited the knowing transmission to minors of "indecent" or certain "patently offensive" communications. Drawing upon *Erznoznik* and *American Booksellers*, both State statute cases, the *Reno* Court said it "may impose a limiting construction on a statute only if it is 'readily susceptible' to such a construction." 521 U.S. at 884. This eliminated any previously implied distinction between First Amendment challenges to State and federal statutes. Moreover, the Court distinguished its criticism of the "open-ended" CDA from "those [cases] in which [the Court has] construed a statute narrowly because the **text** or **other source of Congressional intent** identified a clear line that this Court could draw." *Id.* (emphasis added). By expressly endorsing these two methods of discerning legislative intent, the Court also appeared to close any gap between free speech cases and cases involving other constitutional guarantees. Thus, in any constitutional challenge, federal courts are to use the **text** of a statute to discern legislative intent and, where possible, a narrowing construction. Where a narrowing construction cannot be grounded in a textual approach, **other sources** of legislative intent can still supply the rationale for narrowing. This focus on sources of legislative intent is the other side of the same coin used in *DeBartolo*, which said a court is to adopt a narrowing construction "unless plainly contrary" to legislative intent. 485 U.S. at 575. *Reno* also repeated the admonition

that courts "will not rewrite a law to conform it to constitutional requirements." 521 U.S. at 884-85, quoting *American Booksellers*, 484 U.S. at 397 (quotation marks omitted). But, by juxtaposing this admonition with its approval of "the text or other source of Congressional intent," the Court implicitly limited the admonition to cases where such sources provide no basis for a narrowing construction.

Brought to this point, the cardinal rule may be summarized as follows: federal courts must not construe a statute in a way that leaves doubts about its constitutionality, if the text or other source of legislative intent furnishes the basis for a narrowing construction that will avoid those doubts. It is a rule applicable to statutes generally, including State statutes dealing with abortion. *See, e.g., Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 441 (1983); *Planned Parenthood v. Ashcroft*, 462 U.S. 476, 493 (1983).

Finally, lest there be any doubt about Nebraska jurisprudence, the Supreme Court of that State likewise has a practice of construing statutes to avoid constitutional difficulty. Nebraska courts are "required to construe a penal statute so as to give it an interpretation which meets constitutional requirements if such can reasonably be done." *State v. Kipf*, 450 N.W.2d 397, 403 (1990); *accord State v. Garza*, 496 N.W.2d 448, 454 (1993). If a statute is "susceptible to more than one reasonable construction, a court uses the construction that will achieve the statute's purpose and preserve the statute's validity." *Ehler's v. Perry*, 494 N.W.2d 325, 334 (1993). Unfortunately, the Nebraska courts never had the chance to apply these canons to the law of their State, and the Eighth Circuit utterly failed to do so, just as it failed to apply the cardinal rule of this Court.

APPLICATION OF THE RULE TO THE NEBRASKA STATUTE

A word is not a crystal, transparent and unchanged, it is the skin of a living thought and may vary greatly in color and content according to the circumstances and the time in which it is used.

Towne v. Eisner, 245 U.S. 418, 425 (1918) (Holmes, J.).

This observation by an eminent jurist should be borne in mind in approaching this case, which turns on the meaning of the words used by Nebraska in writing its statute banning partial birth abortion. "Partial birth abortion" is defined in the statute as:

> an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. For purposes of this subdivision, the term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a **substantial portion** thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.

Neb. Rev. Stat. § 28-326(9) (1998) (emphasis added).

The Eighth Circuit construed the Nebraska statute to ban dilation and evacuation ("D&E"), the most common abortion method in the second trimester. So construed, the statute was held to impose an "undue burden on a woman's right to choose to have an abortion" and was thus declared unconstitutional. *Carhart v. Stenberg*, 192 F.3d 1142, 1151 (1999).[3] In reaching this conclusion, the court said the "crucial problem" was the term "substantial portion," which "is nowhere defined in the statute." *Id.* at 1150. More specifically, the question was how much of the unborn child must be delivered into the vagina before the "substantial portion" element is met. The court made no effort to construe this term – or any other statutory term – in light of Nebraska law. The Attorney General of Nebraska said the child must be delivered up to his head, as is done in the D&X procedure that the statute targets. The court of appeals rejected this interpretation without analysis. It concluded that fetal arms or legs qualify as a "substantial portion" and that, because such delivery of limbs occurs in many D&E abortions, the Nebraska statute sweeps too broadly to be constitutional.

In reaching its decision, the Eighth Circuit acknowledged the cardinal rule of statutory construction, then turned around and ignored it. It first said, "In interpreting the statute, it is our duty to give it a construction, if **reasonably possible**, that would avoid constitutional doubts." *Id.* (emphasis added). Yet, only a few sentences later, the court abandoned this standard and baldly declared: "if 'substantial portion' means an arm or a leg – **and surely it must** – then the ban created by [the Nebraska statute] encompasses both the D&E and the D&X procedures." *Id.* (emphasis added). Similarly, it declared that it "agree[s] with the District Court's assessment that in any **sensible and ordinary** reading of the word, a leg or arm is 'substantial.' " *Id.*, quoting *Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1129 (D. Neb. 1998)

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[3] Since the Eighth Circuit did not reach other aspects of the decision by the district court, the *Amici* will not address those issues, other than to note their view that, properly construed, the Nebraska statute should survive scrutiny there as well.

(emphasis added; internal quotation marks omitted). The inconsistency is obvious. Identifying the "sensible and ordinary" meaning of a word is a fundamentally different task than deciding whether an interpretation is "reasonably possible" in the context of a particular statute. The court of appeals should have followed Justice Holmes by looking for the "living thought" beneath the words at issue. Instead, it treated those words as "transparent and unchanged." This was error.

If the court of appeals had adhered to the cardinal rule of construction, it would have adopted the interpretation advanced by the Attorney General of Nebraska. Under the approach approved in *Reno*, the court should have examined both the "text" of the Nebraska statute and "other sources" of legislative intent. 521 U.S. at 884. Both of these sources identify a clear line between the D&X procedure, which is prohibited, and the D&E procedure, which is allowed.

The Textual Approach Supports A Narrow Reading.

The Nebraska Supreme Court has recognized that the word "substantial" has a broad range of possible meanings. *See, e.g., George A. Hormel & Co. v. Hair*, 426 N.W.2d 281, 284 (1988) (" 'Substantial' has been defined to mean 'material,' 'important,' 'massive,' or 'considerable in amount.' ") (citation omitted). It has also recognized that the meaning to be attached to the term depends on context, and that the term can mean what the State contends it means here – "almost all of" something. *See, e.g., Jones v. Elliott*, 108 N.W.2d 742, 748 (1961) ("substantial performance" of a construction contract is a close "approximation to complete performance"). This alone is enough to rebut the Eighth Circuit's unsupported conclusion that a "substantial portion" of an unborn child "surely" means something less than delivery up to the head.

Nebraska's interpretation of its statute is also supported by returning the disputed words to the place where they are found and examining them there in the light of the applicable canons of construction. As this Court has recognized, one such canon is "to give effect, if possible, to every word." *Reiter v. Sonotone*, 442 U.S. 330, 339 (1979). The same familiar canon applies in Nebraska. *Richardson v. Board of Education*, 290 N.W.2d 803, 807 (1980) ("We must presume that the Legislature intended every provision of the statute to have a meaning."); *accord, State v. Glover*, 325 N.W.2d 155 (1982). What meaning does the word "substantial" bring? In order to answer this question, it is helpful to consider the statute as it would appear with "substantial" omitted. In such a case, the law would still not be violated unless, *inter alia*, the portion of the child "deliver[ed] into the vagina" were capable of being the subject of "a procedure that the person performing such procedure knows will kill the unborn child." When such a hypothetically abbreviated statute is analyzed by a textual approach, fetal limbs alone would arguably qualify because, by their disarticulation, a physician could kill the fetus and, as the record shows, this is a recognized procedure.[4] But, there is no recognized procedure in which a physician draws into the vagina a fetal part *smaller* than a limb for the purpose of performing a fatal procedure. When the word "substantial" is added, it must bring added meaning. It

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[4] Some States adopted partial birth abortion bans based on the 1995 federal model, rather than the 1997 federal model that introduced the words, "substantial portion." While those earlier States would not have the benefit of the same textual argument made here, they have other textual arguments, as do States using the 1997 model. All of these statutes also have the benefit of a narrowing construction based on legislative intent.

requires the delivery of a greater portion of the child than would be required without that additional term. Thus, more than fetal limbs must be delivered.

More, but how much more? And, why is Nebraska correct to say that the child must be delivered up to its head? A persuasive answer can be found in the circumstances of fetal anatomy and abortion practice. First, the fetal torso is an anatomical feature having far greater girth than fetal limbs and requiring significantly more cervical dilation to deliver. If the cervix has sufficiently dilated to permit a portion of the torso to be drawn through the cervix, the rest of the torso follows easily. Second, there is no evidence of any abortion technique in which the physician pauses *mid-torso* to perform the procedure that will kill the child. Even if there may be rare circumstances where a different result occurs, it is reasonable to judge the **meaning** of "substantial" based on the **typical and ordinary** circumstances, not the extraordinary ones.[5] Thus, analyzing the text of the statute supports the reasonableness of the interpretation offered by Nebraska.

Other Sources of Legislative Intent Support A Narrow Reading.

The courts are not confined, however, to a textual approach. As *Reno* shows, other sources of legislative

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[5] Similarly, even if the Respondent could speculate about some hypothetical procedure in which a physician would pause mid-torso to deliver the lethal blow, that is not enough. A plaintiff cannot "have a regulation wiped off the books . . . merely by showing that it will be impermissibly vague in the context of some hypothetical application." *Sweet Home Chapter of Comm. for a Greater Oregon v. Babbitt*, 1 F.3d 1, 4 (D.C. Cir. 1993).

intent can also draw "a clear line" in interpreting the sweep of a statute. Nebraska courts consult the legislative purpose, and place on the statute a "construction that best achieves the statute's purpose." *Willers v. Willers*, 587 N.W.2d 390, 394 (1998); *Brown v. Wilson*, 567 N.W.2d 124, 128 (1997). The public record surrounding passage of the Nebraska statute – as well as the public history of these times – leads to the conclusion that the Nebraska legislature's purpose was to ban only the D&X procedure.

The intent of the Nebraska legislature is confirmed by examining the history of the federal legislation on which the Nebraska statute is based.[6] In 1995 and 1997, Congress passed legislation to ban partial birth abortions. Although both bills were vetoed by the President, they served as models for similar legislation by the States. Passed in 1997, the Nebraska statute was modeled on the 1997 version of the federal bill.[7] It is, therefore, reasonable to infer that the Nebraska legislature intended to

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[6] The *Amici* will not duplicate Nebraska's discussion of its own legislative history, but wish to make the point that the history of the federal model is a sufficient basis on which to find legislative intent for Nebraska's statute as well as for all other State statutes based on the federal legislation.

[7] The federal bill gave the following definition:

> (b)(1) . . . "partial-birth abortion" means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.
>
> (3) " . . . vaginally delivers a living fetus before killing the fetus" means deliberately and intentionally delivers into the vagina a living fetus, or a substantial portion thereof, for the purpose of performing a procedure the physician knows will kill the fetus, and kills the fetus.

H.R. 1122, 105th Cong., 1st Sess. (1997).

address the same problem as Congress. The legislative history of the federal bill is useful in ascertaining the legislative intent underlying the State version.

In its report on the 1997 bill, the Judiciary Committee of the U.S. House of Representatives explained that the purpose of the federal legislation is to prohibit the D&X procedure. H.R. Rep. No. 105-24 (1997) ("the Report"). In describing "partial birth abortion," the Report quoted a presentation about D&X by Dr. Martin Haskell, an inventor of the procedure. That presentation included Dr. Haskell's discussion about how much of the unborn child is to be delivered into the vagina before the lethal blow is delivered:

> [Using forceps] the surgeon reliably grasps a lower extremity . . . and pulls the extremity into the vagina . . . . With a lower extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities. **The skull lodges at the internal cervical os.** At this point [holding the fetus in place] the surgeon then forces the scissors into the base of the skull or into the foramen magnum. . . .

Id. at 3, quoting Martin Haskell, M.D., "Dilation and Extraction for Late Second Trimester Abortions" (1992) (emphasis added).

No abortion technique other than the Haskell D&X was described by the Report as falling into the category of "partial birth abortion."[8] Since it was clearly the

[8] One could conceive of variations of the D&X that the statute would also ban (*e.g.*, killing by lethal injection, instead of brain suction). Such potential variations do not figure in this case or current abortion practice and need not be distinguished from the Haskell D&X. Such potential variations are subsumed here under the term "D&X."

legislative intent to ban the D&X procedure, and since that procedure clearly requires delivery of the child up to its head, it is reasonable to construe the words "substantial portion" as being met in the federal bill only when the child has been so delivered. And, since the State law mirrors the federal bill, it is likewise reasonable to say that the words at issue here require delivery of the child up to his head.

This approach compares favorably with the one used in *United States v. Grace*, 461 U.S. 171 (1983). At issue there was a federal statute, 40 U.S.C.A. § 13k, that prohibited picketing and leafleting on the grounds of the Supreme Court. The grounds were defined to encompass the entire block on which the Supreme Court building is located, bounded by the curbs of the bordering streets. 40 U.S.C.A. § 13p. Thus, while no separate mention was made of sidewalks, the statute was drawn in terms so broad as to encompass them by a literal reading of its terms. Treating sidewalks as a traditional public forum, this Court held that § 13k was unconstitutional insofar as it banned picketing and leafleting occurring there. Yet, the entire statute was not struck down; it was only invalidated as applied to the sidewalks. Even without a textual basis, the Court was able to use legislative intent to draw a dividing line across a plot of ground. Legislative intent should likewise be a sufficient basis on which to draw a dividing line across the body of a fetus. Moreover, the Nebraska statute's use of "substantial portion" provides a textual basis for line-drawing wholly missing in *Grace*. Thus, the Court should simply decide that the Nebraska statute does not apply when only arms and legs are delivered. It only applies when the child has been delivered up to its head. It bans the D&X, not the D&E.

In sum, both the "text" of the Nebraska statute and "other source[s] of [legislative] intent identif[y] a clear

line that this Court could draw." *Reno*, 521 U.S. at 884. Of course, the task of line-drawing here is one more properly performed by the Supreme Court of Nebraska.[9] As for their part, federal courts should "assume . . . that a state court presented with a state statute specifically governing . . . abortion . . . procedures will attempt to construe the statute consistently with constitutional requirements." *Akron*, 462 U.S. at 441.

FUTURE OF THE RULE: TWO PROPOSED COROLLARIES

For this Court to accept the narrowing construction offered by Nebraska – and to reverse the court of appeals – are the only actions needed to resolve the present controversy. That can be done quite concisely. But, the Court should consider doing more. The failure of the court of appeals to abide by the cardinal rule in the case at bar is not an isolated occurrence. Other federal courts have committed similar errors. Indeed, "[f]ederal courts have always struggled to say how far they should go in defining state statutes so they are constitutional." *Eubanks*

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[9] There is no reason to believe that the Nebraska court would ignore its own canons of construction, or that there is some other obstacle to its arriving at a perfectly plausible construction of "substantial portion" that would eliminate or narrow federal constitutional questions by excluding D&E from the statute's reach. *See, e.g., State v. Burke*, 408 N.W.2d 239, 246 (1987) (saving statute from First Amendment overbreadth challenge by rejecting construction of a term that would cause statute to reach protected conduct); *cf. Central States Found. v. Balka*, 590 N.W.2d 832, 839 (1999) (although statute lacks explicit procedural requirements, "we read the statute as including the procedural requirements necessary to satisfy the Fourth Amendment.").

v. Stengel, 28 F. Supp. 2d 1024, 1037 (W.D. Ky. 1998), *appeal docketed*, No. 98-6671 (6th Cir. Dec. 11, 1998). This case provides an excellent opportunity for the Court to give additional guidance on how the rule is to be applied.

Nowhere is the failure to adhere to the rule more evident than in cases dealing with the sensitive and profound issue of abortion. One example of such a failure is found in *Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 523 U.S. 1036 (1998), where the Sixth Circuit struck down Ohio's ban on the D&X procedure. As suggested by the dissenting judge, the majority not only disregarded the cardinal rule of construction, but turned the rule on its head, "strain[ing] to interpret" the statute "so as to make the burden . . . appear 'undue' in violation" of Supreme Court precedent. *Id.* at 212. One commentator described the decision this way:

> Directly contradicting Supreme Court precedent, the *Voinovich* court failed to seek a constitutional interpretation of the D&X ban. Rather than adopting a consistent method of statutory interpretation, the court repeatedly changed its interpretive position in order to push the law toward unconstitutionality.
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> * * *
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> The Sixth Circuit crafted an opinion unconstrained by the Supreme Court's "cardinal principle" or any other standard of statutory interpretation. Rather, the opinion's only consistent interpretive principle is that standards of interpretation are selectively and temporarily employed and rejected to flout the Supreme Court's mandate and find the statute unconstitutional.

Comment, 112 Harv. L. Rev. 731, 734, 736 (1999).

Other courts have struck down partial birth abortion statutes based on a cramped understanding of their mandate to adopt narrowing constructions whenever possible. A leading example is *Planned Parenthood of Central New Jersey v. Verniero*, 41 F. Supp. 2d 478 (D.N.J. 1998), *appeal docketed*, No. 99-5042 (3d Cir. Feb. 2, 1999), a case that vividly illustrates the need for additional guidance. In striking down the New Jersey partial birth abortion ban, the court acknowledged the cardinal rule, but mistakenly believed that it applies only in "close cases." *See id.* at 486. This mistake was apparently engendered by that court's misreading of *Chapman v. United States*, 500 U.S. 453 (1991). *Chapman* provides no guidance on how far a court may go in accepting a State's construction of its statute before it ventures into the forbidden ground of rewriting it. That guidance was provided by *Reno*, 521 U.S. at 884-85. The *Verniero* court acknowledged *Reno*, but only took note of the "readily susceptible" term found there without recognizing the broad use of text and other sources of legislative intent that *Reno* authorizes within the scope of that term.

Additional guidance is also needed to prompt federal courts to entrust decisions about State law to State courts through use of certification. In *Eubanks*, for example, Kentucky asked the district court to certify its partial birth abortion statute to the Kentucky Supreme Court for a definitive ruling about its meaning. The district court refused, based on its failure to discern a limiting construction to which the statute was "obviously susceptible" and a reluctance to entrust to the State courts a decision that might resolve the entire case. 28 F. Supp. 2d at 1038 n.17.

The "Reasonable Jurist" Corollary

The *Amici* respectfully suggest that the failure to adhere to the rule arises, in part, from an insufficient

focus on the proper role of the federal judiciary in dealing with the meaning of State law. When dealing with federal law – including the federal constitution – "[i]t is emphatically the province and duty of the judicial department to say what the law is." *Marbury v. Madison*, 5 U.S. 137 (1803). And, by the same logic, it is the province and duty of the **State** judiciary to say what the **State** law is. Thus, where a State's highest court has declared what State law means, federal courts may not say otherwise. *Johnson v. Fankell*, 520 U.S. 911, 916 (1997) ("Neither this Court nor any other federal tribunal has any authority to place a construction on a state statute different from the one rendered by the highest court of the state."); *Chicago v. Morales*, 527 U.S. 41, 119 S.Ct. 1849, 1861 (1999) ("We have no authority to construe the language of a state statute more narrowly than the construction given by that State's highest court."). By the same token, where a State's highest court has not yet construed a State statute, it is not the task of the federal courts to displace or preempt that State tribunal by **declaring** what the statute means. Instead, it is the federal court's role to make a **predictive** judgment about how State courts may interpret their own State law. In making this judgment, the federal court should "assume . . . that a state court . . . will attempt to construe the statute consistently with constitutional requirements." *Akron*, 462 U.S. at 441.[10] Accordingly, a federal court should not conclude that the State court would fail in this endeavor **unless** there is simply no saving construction that a reasonable jurist could reach. In sum, the basic principles previously recognized by this Court give rise to the following corollary, which the *Amici* respectfully urge this Court expressly to adopt:

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[10] For Nebraska rules on achieving constitutional constructions, *see supra* at 11.

When a federal court construes a State statute that has not been authoritatively construed by the courts of that State, the federal court shall not reject a proffered interpretation that would avoid constitutional problems, unless the interpretation is one that is not susceptible to debate among reasonable jurists.

This corollary would promote adherence to the Court's cardinal rule by stating more expressly what the focus of federal courts must be when confronted with a constitutional challenge to a new State law. The question is not what **they** believe the State law means, but whether a proposed interpretation is one that is open for their State counterparts to adopt. The "reasonable jurist" test is not new in the law. An analogous approach has been used in *habeas corpus* jurisprudence since *Butler v. McKellar*, 494 U.S. 407 (1990) and *Sawyer v. Smith*, 497 U.S. 227 (1990).[11] The issue is not whether the jurist would have been right or wrong to make a particular ruling on the law, but whether that ruling was open to debate. Similarly, when a federal court is presented with a narrowing construction of a new State law, its task is not to decide whether that construction is right or wrong, but whether it is subject to debate among "reasonable minds" or "reasonable jurists." If so, then the federal court must presume that

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[11] There, the "reasonable jurist" test is part of the non-retroactivity doctrine. Under *Teague v. Lane*, 489 U.S. 288, 310 (1989), "new constitutional rules of criminal procedure will not be applicable to those cases which have become final before the new rules are announced." As the Court has explained, "[a] rule is 'new' for *Teague* purposes whenever its validity under existing precedent is subject to debate among 'reasonable minds' or among 'reasonable jurists.' " *Wright v. West*, 505 U.S. 277 (1992), quoting *Butler*, 494 U.S. at 415, and *Sawyer*, 497 U.S. at 234.

the State court would adopt that construction – or some better one – in order to save the statute from unconstitutionality.

In the case at bar, it was clear error for the Eighth Circuit not to adopt – or even consider – the narrowing construction of the Nebraska statute offered by the Attorney General of that State. It is an error that might well have been avoided – and that would be more easily avoided in the future – if the cardinal rule of construction were stated as directly as the first corollary the *Amici* now propose. The *Amici* respectfully request the Court to adopt that corollary.

The "State Certification" Corollary

The first corollary proposed by the *Amici* would clarify the rules of **substantive** decision-making by federal courts. The second proposed corollary addresses the **procedure** for interpreting State statutes. Reviewing the constitutionality of a State statute is one of the gravest duties that can be undertaken by a federal court. It is especially so when that review leads to a conflict between the court and the State as to the *meaning* of the statute. At one end of the courtroom sits the federal judge, embodying the weight and authority of the United States government. At the other end stands the Attorney General, representing the State government whose statute is under attack. The State government says to the federal that the State law means *this*. And the federal government responds by telling the State that it is wrong about its own statute, and that its law means *that*. We all must "pause to ask: Is this conflict really necessary?" *Arizonans for Official English v. Arizona*, 520 U.S. 43, 75 (1997). Such a conflict between the two governments – each sovereign in its own sphere – is a spectacle that ought to be assiduously avoided. In the

interests of avoiding such conflicts, the *Amici* also propose the following corollary to the cardinal rule of construction:

> **When a federal court construes a State statute that has not been authoritatively construed by the courts of that State, the federal court shall not reject an interpretation advanced by the State, if certification to the State's highest court is available to test the proffered interpretation.**

Such an approach would defuse the conflict – and avoid "friction-generating error" – by shifting the dispute over State statutory interpretation into a State forum. *Arizonans*, 520 U.S. at 79. Whether the State court accepted or rejected the Attorney General's view about the meaning of the State statute, the State would then be the master of its own house.[12] Thus, concerns about comity and federalism would no longer be implicated. On the

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[12] While certification proceedings were pending, the federal court could provide plaintiffs with any necessary protection by a preliminary injunction preventing enforcement of the statute in a manner inconsistent with the proffered interpretation. *See Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 312 n.18 (1979); *Harrison v. NAACP*, 360 U.S. 167, 179 (1959). Of course, "there is no reason to suppose that . . . assurances [given to the Court by state officials concerning the limited scope of the statute] will not be honored by these or other [state] officials not parties to [the] litigation." *Id.* As a result, in most cases there will be no basis for the kind of "precautionary injunction" issued by the Seventh Circuit in *Hope Clinic v. Ryan*, 195 F.3d 857 (7th Cir. 1999) (*en banc*). Indeed, it is a violation of federalism to assume that state officials will adopt and enforce an unconstitutional interpretation of the statute. *Richmond Medical Ctr. For Women v. Gilmore*, 144 F.3d 326, 332 (4th Cir. 1998) (Luttig, J.) (single judge).

other hand, if the State court declined to hear the case, the State would at least have had the opportunity to have construed its own law. Thus, even if the federal court thereafter reached an unfavorable conclusion about the statute, concerns about comity and federalism would be sharply reduced.[13]

As this Court has already recognized, federal courts have authority to certify questions of State law on their own motion. *E.g., Elkins v. Moreno*, 435 U.S. 647, 662 (1978); *Massachusetts v. Feeney*, 429 U.S. 66 (1976). Forty-seven States – including Nebraska – now have certification procedures in place.[14] Neb. Rev. Stat. Ann. § 24-219. While the Court has not yet called for certification in the same terms suggested by the *Amici*, the proposed corollary represents a logical extension of the guidance previously announced by the Court. That guidance is found in various statements that – like the proposed corollary –

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[13] Nevertheless, where the State's highest court has declined to accept certification from a federal district court, the same opportunity should be again provided by any federal appellate court that might be inclined to reject the Attorney General's interpretation. This is so not only because the district court's subsequent decision on the merits may make acceptance of certification more compelling, but also because the State's highest appellate court may prefer to limit the cases it accepts to those certified by another appellate court. *See, e.g., Virginia Soc'y for Human Life v. Caldwell*, 152 F.3d 268 (4th Cir. 1998) (describing acceptance of certification by Virginia Supreme Court when request received from court of appeals, despite earlier rejection of certification request from federal district court).

[14] *See* Schneider, "But Answer Came There None": The Michigan Supreme Court and The Certified Question of State Law, 41 Wayne L. Rev. 273, 275-277 n.1. (1995) (listing forty-three states with certification procedures); Cal. Rules of Ct. Div I R 29-5 (1999); 477.004 R.S.Mo (1999); N.J.Ct.R. 2:12 A (1999); In Re: Certification of Questions of Law (Order) (S. Ct. of Pa. Jan. 12, 2000).

aim at avoiding clashes between State and federal governments, while facilitating an accurate resolution of the constitutional challenge. "Speculation by a federal court about the meaning of a state statute in the absence of prior state court adjudication is particularly gratuitous when . . . the state courts stand willing to address questions of state law on certification from a federal court." *Arizonans*, 520 U.S. at 79 (quoting *Brockett v. Spokane Arcades*, 472 U.S. 491, 510 (1985) (O'Connor, J., concurring) (other citation omitted). *See also, e.g., American Booksellers*, 484 U.S. at 395 (case remanded for certification "where the nature and substance of plaintiffs' constitutional challenge is drastically altered if the statute is read" in a narrower way than plaintiffs propose); *Zant v. Stephens*, 456 U.S. 410, 416 (1982) ("Suffice it to say that the state-law premises of the Georgia Supreme Court's conclusion of state law are relevant to the constitutional issue at hand."); *Arizonans*, 520 U.S. at 77, 79 (certification warranted if it would " 'greatly simplify' an ultimate adjudication in federal court") (citation omitted); *Fiore v. White*, 528 U.S. ___, 120 S. Ct. 469, 473 (1999) (State Supreme Court's answer to certified question "will help determine the proper state-law predicate for our determination of the federal constitutional questions raised in this case."). As this Court has also recognized, a State's proffer of a narrowing construction is important or even decisive evidence of the statute's susceptibility to it. *E.g., Arizonans*, 520 U.S. at 77-78; *American Booksellers*, 484 U.S. at 394-97; *Bellotti v. Baird*, 428 U.S. 132, 143-45 (1976).

There is no sign in the Eighth Circuit's remarkably brief opinion of the slightest interest in what Nebraska courts would have to say about the Nebraska statute. With a dismissive wave of a judicial hand, the court simply announced its own unsupported view that the Nebraska statute "surely" prohibits D&E abortions. Our

Federalism does not permit such cavalier treatment of a new State statute. This Court should correct that grave constitutional error by giving the statute an appropriate narrowing construction or, alternatively, by certifying the question of the statute's proper construction to the Nebraska Supreme Court. In either case, adoption of the proposed corollary would avoid such infringements in the futu e.

CONCLUSION

We live under a constitutional framework that not only divides power among three branches of government, but also between two levels of sovereignty: federal and state. The preservation of that framework depends in no small measure upon the restraint and balance exercised by federal courts when called upon to decide constitutional challenges to State statutes. The cardinal rule of statutory construction – saving statutes whenever possible – is a reflection of the need for restraint and balance. When the rule is not followed, it is nothing less than a violation of constitutional principles, a violation that is not mitigated – but aggravated – when the people of the States have expressed their will on a subject so sensitive and profound as the one at issue here.

The court of appeals failed to follow the cardinal rule, and improperly struck down a Nebraska statute banning partial birth abortion. This Court should correct the error, accept the narrowing construction offered by Nebraska and uphold the statute as constitutional. Moreover, the Court should use this case as an opportunity to undergird constitutional principles by adopting

corollaries to the cardinal rule that will promote restraint and balance in future controversies.

Respectfully submitted,

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IN THE SUPREME COURT OF THE UNITED STATES

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Stenberg, et al.,

Petitioners,

v.

Carhart, et al.,

Respondents.

On Writ of Certiorari to The United States Court of Appeals for the Eighth Circuit

Motion to File a Brief *Amicus Curiae* and Brief *Amicus Curiae* of **Texas Black Americans for Life** and **L.E.A.R.N. (the Life Education And Resource Network)** in support of Petitioner Stenberg

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38 pp

MOTION TO FILE A BRIEF AMICUS CURIAE

Texas Black Americans for Life and **L.E.A.R.N. (the Life Education And Resource Network)** request leave of this Court to file a brief ***amicus curiae*** in support of Petitioner Stenberg in ***Stenberg v. Carhart***, #99-830. These organizations were founded by African-Americans who are concerned about the racial genocide aspects of abortion. The members thereof also feel a need to speak out about the link between slavery and abortion. The brief focuses on relevant matter not otherwise brought to the attention of this Court.

We are aware that this Court declined the invitation to reconsider the nonpersonhood holding of ***Roe v. Wade*** in this case, but this brief deals with a unique and slightly different perspective of that issue as it is presented by the facts of this case---constitutional protection even in the absence of Fourteenth Amendment personhood. For example, no one, it would seem, has picked up on the fact that between the time of the outlawing of slavery by the Thirteenth Amendment and the time of the ratification of the Fourteenth Amendment, it was possible for one to have constitutional protection which the courts were bound to respect, even though (in the absence of the Fourteenth Amendment) we African-Americans, for instance, were still subject to the "nonpersonhood" holding of this Court in ***Dred Scott*** (***Scott v. Sandford***, 60 U.S. (19 How.) 393, 15 L.Ed. 691 (1857)).

Quite understandably, this point apparently has not been discussed in the cases or by the commentators. Our unique perspective as victims of slavery, however, gives us insight into this issue not commonly obtainable elsewhere. This

brief is, to the best of our knowledge, the sole source of a discussion of this issue, which we tailor to the facts of this case concerning partial-birth abortions. In order to give the Court a complete understanding of this point, we first examine this issue from its historical perspective, and then add points and details which may illuminate the topic.

This Court, we know has been flooded before with numerous briefs detailing the biological basis for establishing the humanity of the unborn, and in this case those points will no doubt be well briefed again. This Court likewise has been advised before of the wonders of modern medicine which allow surgeries to be performed in the womb. All that being said, we leave the discussion of those points in detail to those other briefs.

We were advised in telephone conversations that our requests to counsel for the petitioner and for the respondent were timely made. However, Respondent Carhart, we have been told, has agreed to consent to only ten briefs ***amicus curiae***, and the priorities of the office of Petitioner Stenberg were to give consent for those ten briefs to other, more prestigious organizations. Neither party has given express consent. We therefore respectfully request that this Court grant us leave to file this brief.

Counsel of record on this brief is experienced at practice in this Court as counsel of record in the filing of petitions for a writ of certiorari (and in being co-counsel for same), and as counsel of record on certain ***amici*** briefs filed with this Court. These have all been in cases pertaining to abortion. The text of this brief, 27 pages, is set in the same point size (12 point) as this motion.

99-830

IN THE SUPREME COURT OF THE UNITED STATES

Stenberg, et al.,

Petitioners.

v.

Carhart, et al.,

Respondents.

On Writ of Certiorari to The United States Court of Appeals for the Eighth Circuit

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Brief *Amicus Curiae* of **Texas Black Americans for Life** and **L.E.A.R.N. (the Life Education And Resource Network)** in support of Petitioner Stenberg

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INTEREST OF THE AMICI

Texas Black Americans for Life and L.E.A.R.N. (the Life Education And Resource Network) are organizations founded by African-Americans who are concerned about the racial genocide aspects of abortion. The members thereof also feel a need to speak out about the link between slavery and abortion.[1] This brief is filed by motion, not by consent.

SUMMARY OF ARGUMENTS

I. In the constitutional scheme of things, this Court recognized even in ***Dred Scott*** that those who are not persons within the meaning of the United States Constitution could have rights under state law which the federal courts would be bound to respect. The right of the State of Nebraska to offer this protection to the unborn is subsumed within this sovereign right. For surely the enactment of the **Fourteenth Amendment** did not diminish the scope of protections which one might have under the law even in ***Dred Scott***. Pp. 2-13.

Furthermore, freed African-American slaves had constitutional protection via the **Thirteenth Amendment** even before the enactment of the **Fourteenth Amendment**, which overturned the holding of this Court in ***Dred Scott*** which said that we were not persons. Pp. 13-14.

The scope of these protections extends to the unborn every bit as much as it did to us. Consequently, a portion of ***Roe***

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1 Counsel of record is the sole author of this brief. No monetary contribution was made toward its preparation and filing by any person other than members of the ***amici*** organizations or by counsel of record.

v. Wade must be reviewed for the proper adjudication of this case even though the question of **Fourteenth Amendment** personhood need not be. Pp. 14-15.

Such a review of ***Roe*** is imperative now because the honor of this Court is at stake. Pp. 15-22.

The reconsideration of a portion of ***Roe*** does not jeopardize the constitutional basis of liberty interests discussed therein. Pp. 22-23. Nor does the **First Amendment** disallow a recognition that the states have the sovereign right to recognize the natural personhood of the unborn. Pp. 23-25.

II. On the facts, the idea that placing an unborn child into a breech-birth position can be healthy for the mother, when a live delivery is possible without such a maneuver, is implausible. Pg. 25.

III. Judge Samuel Sewall of the Salem witchcraft trials set an example for us by his courage, honesty, and character. Pp. 26-27.

ARGUMENTS

I. Constitutional Protection Of One's Interests May Exist Even Without Fourteenth Amendment Personhood.

This Court has been flooded before with numerous briefs detailing the biological basis for establishing the humanity of the unborn, and no doubt in this case it shall be so again. This Court likewise has been advised before of the wonders of modern medicine which allow surgeries to be performed in the womb. All that being said, we shall leave

the discussion of those points in detail to those other briefs.

A. Even In ***Dred Scott*** This Court Recognized The Rights Of Personhood Which May Be Had Under State Law.

On one prior occasion, in ***Planned Parenthood v. Casey***,[2] these same ***amici*** brought to this Court's attention certain statements of this Court from its ***Dred Scott*** decision in which this Court affirmed the sovereign right of the states to clothe those who are subject to its jurisdiction with protection which even this Court is bound to recognize and honor. Whereas before we simply made reference to the passages wherein those quotes can be found, we now wish to state the quotes in full:

> "In discussing this question, we must not confound the rights of citizenship which a state may confer within its own limits, and the rights of citizenship as a member of the Union. It does not by any means follow, because he has all the rights and privileges of a citizen of a State, that he must be a citizen of the United States. He may have all the rights and privileges of the citizen of a State, and yet not be entitled to the rights and privileges of a citizen in any other State. ***For, previous to the adoption of the Constitution of the United States, every State had the undoubted right to confer on whomsoever it pleased the character of a citizen, and to endow him with all its rights.*** But this character, of course, was confined to the boundaries of the State,

2 ***Planned Parenthood v. Casey***, 505 U.S. 833, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992).

> and gave him no rights or privileges in other States beyond those secured to him by the laws of nations and the comity of States. ***Nor have the several States surrendered the power of conferring these rights and privileges by adopting the Constitution of the United States. Each State may still confer them upon an alien, or any one it thinks proper, or upon any class or description of persons;*** yet he would not be a citizen in the sense in which that word is used in the Constitution of the United States, nor entitled to sue as such in one of its courts, nor to the privileges and immunities of a citizen in the other States. The rights which he would acquire would be restricted to the State which gave them. The Constitution has conferred on Congress the right to establish an uniform rule of naturalization, and this right is evidently exclusive, and has always been held by this court to be so. Consequently, no State, since the adoption of the Constitution, can, by naturalizing an alien, invest him with rights and privileges secured to a citizen of a State under the federal government, although, ***so far as the State alone was concerned, he would undoubtedly be entitled to the rights of a citizen, and clothed with all the rights and immunities which the Constitution and laws of the State attached to that character.***"[3]

Later in that same case, this Court went on to say,

> "The Government of the United States had no right to interfere for any other purpose but that of protecting the rights of the owner, leaving it

3 ***Scott v. Sandford***, 60 U.S. (19 How.) 393, 405-406, 15 L.Ed. 691, 700-701 (1857) (emphasis supplied).

> altogether with the several States to deal with this race, whether emancipated or not, as each State may think justice, humanity, and the interests and safety of society require. ***The States evidently intended to reserve this power exclusively to themselves.***"[4]

To say that the states can not now protect the rights of the unborn is to say that *Dred Scott* went too far in allowing the recognition of personhood; it is also to say that *Dred Scott* did not go far enough in prohibiting the recognition of personhood. And to say (as this Court did in *Roe v. Wade*),[5] that all this is somehow accomplished by the **Fourteenth Amendment**,[6] which was intended to overrule *Dred Scott* to the extent that this Court *did* refuse to recognize personhood, is to turn the **Fourteenth Amendment** inside out and stand it on its head, to put it mildly.

Granted, under the **Fourteenth Amendment**, the question of what to do with any class of persons is no longer reserved exclusively to the states. But it cannot be the case that the **Fourteenth Amendment** actually took away from the states "the undoubted right to confer on whomsoever it pleased the character of a citizen, and to endow him with all its

4 60 U.S. (19 How.) at 426, 15 L.Ed. at 709 (emphasis supplied).

5 *Roe v. Wade*, 410 U.S. 113, 152-153, 93 S.Ct. 705, 726-727, 35 L.Ed.2d 147, 176-177 (1973).

6 All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws. U.S. Const. amend. XIV, § 1.

rights" which this Court, as we say, took note of in *Dred Scott*.[7] Rather, the **Fourteenth Amendment** added to the Constitution enabling power for the federal government to increase and expand the protections of the law and establish a recognized, uniform minimum of what personhood is. It most certainly did not give the federal government power to breach the state/federal barrier and take away personhood which might otherwise already exist under state law.

The power to grant the protection which the State of Nebraska grants to the unborn in the instant case is subsumed within the sovereign power of the states recognized in *Dred Scott*. For the granting of the protection given by this statute is an exercise of those very sovereign powers conceded therein by this Court, albeit to a slightly lesser extent than the full measure of sovereign power which this Court knew it must honor in *Dred Scott*.

Contrary to what some would have us believe, this concept does not enable the states to trample on the rights secured by the U.S. Constitution. Prof. Dworkin, for instance, has expressed the fear that an unencumbered right of the states to endow personhood on anything could lead to a diminution of First Amendment rights, since making trees persons would perhaps mean they could not be cut down, thereby putting an end to all publishing.[8]

This Court, however, has never had any trouble before distinguishing between the constitutional rights of natural

7 60 U.S. (19 How.) at 405, 15 L.Ed. at 701.

8 **Unenumerated Rights: Whether and How *Roe* Should Be Overruled**, 59 U.Chi.L.Rev. 381, 400-401 (1992). ***See also, Casey, supra***, 505 U.S at 912-913, 112 S.Ct. at 2839, 120 L.Ed.2d at 738-739 (Stevens, J., concurring in part and dissenting in part).

persons and those of artificial persons (e.g. a supposed Fifth Amendment right of a corporation against self-incrimination).[9] For as this Court made clear, natural persons have retained rights, whereas artificial persons have no retained rights; artificial persons have only those rights created by positive law.[10] Consequently, the personhood of trees would have to yield to the retained First Amendment rights of a natural person. Also, trees have no human life which can either be protected or taken away from them, whereas unborn children do.

Let us consider for a moment the position of Prof. Dworkin in some detail. He said,

> "The suggestion that states are free to declare a fetus a person... assumes that a state can curtail some persons' constitutional rights by adding new persons to the constitutional population. The constitutional rights of one citizen are of course very much affected by who or what else also has constitutional rights, because the rights of others may compete or conflict with his. So any power to increase the constitutional population by unilateral decision would be, in effect, a power to decrease rights the national Constitution grants to others.
>
> "...If a state could declare trees to be persons with a constitutional right to life, it could prohibit publishing newspapers or books in spite of the First Amendment's guarantee of free speech, which could not be understood as a license to kill... Once we

9 ***Hale v. Henkel***, 201 U.S. 43, 74-75, 26 S.Ct. 370, 378-379, 50 L.Ed. 652, 665-666 (1906).
10. Ibid.

> understand that the suggestion we are considering has that implication, we must reject it. If a fetus is not part of the constitutional population, under the national constitutional arrangement, then states have no power to overrule that national arrangement by themselves declaring that fetuses have rights competitive with the constitutional rights of pregnant women."[11]

Now let us look further at this Court's statements in ***Dred Scott***.

> "It is very clear, therefore, that no State can, by any Act or law of its own, passed, since the adoption of the Constitution, introduce a new member into the political community created by the Constitution of the United States. It cannot make him a member of this community by making him a member of its own. And for the same reason it cannot introduce any person, or description of persons, who were not intended to be embraced in this new political family, which the Constitution brought into existence, but were intended to be excluded from it."[12]
>
> *****
>
> "It is true, every person, and every class and description of persons, who were at the time of the adoption of the Constitution recognized as citizens in the several States, became also citizens of this new political body; but none other; it was formed by them, and for them and

11 ***See***, **Unenumerated Rights**, ***supra***, at 400-401.
12 60 U.S. (19 How.) at 406, 15 L.Ed. at 701.

their posterity, but for no one else. And the personal rights and privileges guarantied [sic] to citizens of this new sovereignty were intended to embrace those only who were then members of the several state communities, or who should afterwards, by birthright or otherwise, become members, according to the provisions of the Constitution and the principles on which it was founded. It was the union of those who were at that time members of distinct and separate political communities into one political family, whose power, for certain specified purposes, was to extend over the whole territory of the United States. And it gave to each citizen rights and privileges outside of his State which he did not before possess, and placed him in every other State upon a perfect equality with its own citizens as to rights of persons and rights of property; it made him a citizen of the United States."[13]

*****

"This case [cited therein], however, strikingly illustrates the consequences that would follow the construction of the Constitution which would give the power contended for, to a State. It would, in effect, give it also to an individual. For if the father of young Darnall had manumitted him in his lifetime, and sent him to reside in a State which recognized him as a citizen, he might have visited and sojourned in Maryland when he pleased, and as long as he pleased, as a citizen of the United States; and the state officers and tribunals would be compelled, by

13 60 U.S. (19 How.) at 406-407, 15 L.Ed. at 701.

the paramount authority of the Constitution, to receive him and treat him as one of its citizens, exempt from the laws and police of the state in relation to a person of that description, and allow him to enjoy all the rights and privileges of citizenship, without respect to the laws of Maryland, although such laws were deemed by it absolutely essential to its own safety."[14]

Were these words in ***Dred Scott*** and the law review article perhaps written by the same person, one might wonder? Does the Court not see the parallels between the reasoning of Prof. Dworkin today and its own statements in ***Dred Scott***? And are the similarities not striking?

The one important difference between what this Court said in ***Dred Scott*** and what Professor Dworkin is saying is that in ***Dred Scott***, this Court was willing to allow one to have personhood for purposes of state law within the given state which had granted such personhood. Professor Dworkin, however, takes a position even more hostile than ***Dred Scott*** to the recognition of rights which one might have.

Note well, please, that in ***Dred Scott*** this Court reasoned that no offense against the constitutional population is committed within the boundaries of the state which would recognize one's personhood; this would only be the case if the Constitution were to then require other states to recognize such personhood.

By Prof. Dworkin's analysis, however, the constitution now enables this Court to move into the jurisdiction of state law and abolish personhood and other such protections

14 60 U.S. (19 How.) at 425, 15 L.Ed. at 709.

offered thereby. Such a position also takes the view, by implication, that ***Dred Scott*** did not go far enough in refusing to recognize rights, and that ***Dred Scott*** went too far to the extent that it ***would*** allow one's rights to be recognized and vindicated by the states. And similarly, through his acceptance of ***Roe***, Prof. Dworkin sees all of this as somehow being accomplished by the **Fourteenth Amendment**. How phenomenal.

Now, as to the question of whether the sovereign right of the states to recognize natural personhood includes a recognition of such rights in the unborn, let the Court consider one Southern case from 1820, ***State v. Jones***, in which a criminal defendant claimed he could not be charged with the murder of a slave on the grounds that a slave is not a person. The court held, however, that killing a slave was every bit as much a murder as killing an unborn child.[15] The reasoning of that case, we note, impeaches both the reasoning and the recitation of the history of the rights of African-Americans in ***Dred Scott***.

For the Mississippi court even expressly noted therein that the Constitution of the United States refers to slaves as persons.[16] The U.S. Constitution, after all, never did refer to African-Americans as three-fifths of a person. It has always called us persons, but said that only three-fifths of us would be counted for purposes of a census.[17] And this

15 ***State v. Jones***, 2 Miss. 39, 40, Walker 83, 85 (June Term, 1820).
16 2 Miss. at 39, Walker at 84.
17 Representatives and direct taxes shall be apportioned among the several states which may be included within this Union, according to their respective numbers, which shall be determined by adding to the whole number of free persons, including those bound to service for a term of years, and excluding Indians not taxed, three-fifths of all other ***persons***. **U.S. Const. art. 1, §. 2, cl. 3** (emphasis supplied).

Southern court equated the unborn with us African-American persons.

This is precisely the type of sovereign right of the states to recognize personhood which this Court was referring to in ***Dred Scott***. This is how the rights of African-Americans were vindicated in the State of Mississippi at the time, even though African-Americans were not recognized as being persons within the meaning of the U.S. Constitution. This Court must recognize that the states still similarly possess this character to protect the unborn to this day, just as the court in Mississippi said in 1820.

We would also remind this Court that, prior to the development of the Incorporation Doctrine, it was simply hornbook law that the Bill of Rights protected the rights of the citizens of the states against encroachment by a foreign jurisdiction---the federal jurisdiction. This is still supposed to be the case today, of course. But in ***Roe***, this Court justified its decision in part on the **First, Fourth, Fifth,** and **Ninth Amendments,**[18] thereby actually using the Bill of Rights to render the unborn (who otherwise would be protected under state law) helpless against an encroachment of federal power on their rights which this Court even in ***Dred Scott*** would not have dared to trespass against. Again, this turns the **Fourteenth Amendment**, the basis for the Incorporation Doctrine, on its head.

Were we not warned about such things, however? As Justice Brandeis said in ***Olmstead v. U.S.***,

> "Experience should teach us to be most on our guard to protect liberty when the government's

18 410 U.S. at 152, 93 S.Ct. at 726, 35 L.Ed.2d at 176.

> purposes are beneficent... The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning, but without understanding."[19]

B. Constitutional Protection Also Exists Under The Thirteenth Amendment Even In The Absence Of Personhood Within The Meaning Of The Fourteenth Amendment.

The idea that one could have constitutional protection even in the absence of federal personhood may also be seen in the relationship between the **Thirteenth and Fourteenth Amendments**. The **Thirteenth Amendment**[20] was declared ratified in December of 1865. But it was only under the **Fourteenth Amendment** that this Court's holding in ***Dred Scott***[21] that African-Americans are not persons was overturned. That would not come until 1868. For over two years, African-Americans had constitutional protection under the **Thirteenth Amendment** without even being persons.

Now, how were these rights to be vindicated? The answer stems from the idea that in our constitutional scheme of things, no one level or branch of our governments is entrusted with all the rights which we hold.

As nearly as we can tell, prior to the ratification of the **Fourteenth Amendment,** if any of our people were still being held in slavery, they would have to appeal to the

19 ***Olmstead v. United States***, 277 U.S. 438, 479, 48 S.Ct. 564, 572-573, 72 L.Ed. 944, 957 (1928) (Brandeis, J., dissenting).
20 Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction. **U.S. Const. amend. XIII, § 1.**
21 60 U.S. (19 How.) at 404-406, 15 L.Ed. at 700-701.

federal authorities to step in---either by the use of the sword, or by judicial process---and intervene in our behalf. On the other side of the coin, however, we note that even without our personhood, there were certain things which could not be done to us (i.e. hold us in slavery, or in involuntary servitude) by any private individual or government entity. For despite our lack of personhood, it was still the case that, immediately following the ratification of the **Thirteenth Amendment,** no court---federal or state---could have the authority to issue any order which would violate that constitutional protection against slavery which we then did have.

We bring this matter to the Court's attention in further support of the point that there does not even have to be federal personhood for there to be a constitutional shield against government action, even by a federal court. But this idea does have further relevance as well. For under ***Roe***, there simply is no definition of property right which the mother's right over the unborn child does not fit.[22] We would remind the Court that "slave"[23] and "slavery"[24] are defined, ***inter alia***, as the ownership of a human being as chattel property.

C. A Portion of ***Roe v. Wade*** Must Be Reviewed For The Proper Adjudication Of This Case Even Though The Question Of Fourteenth Amendment Personhood Need Not Be.

It being the case that there may be state law personhood which the federal courts are bound to respect, the Court

22 Ralph E. Boyer, et al., The Law of Property §§ 1.1-1.3 (4th ed. 1991). Roger A. Cunningham, et al., The Law of Property §§ 1.1-1.2 (2nd ed. 1993).
23 Webster's New Universal Unabridged Dictionary 1705 (Deluxe 2nd ed. 1979).
24 Black's Law Dictionary 1393 (7th ed. 1999).

need not revisit its holding in *Roe* that the unborn are not persons within the meaning of the **Fourteenth Amendment** for the proper adjudication of this case. For where there is adequate state law protection of one's rights as a natural person, that point is simply moot.

The Court may---and indeed should---await the proper case for revisiting its holding in *Roe* that the unborn are not persons within the meaning of the **Fourteenth Amendment**, one in which the facts are well-developed at trial, and the case is properly briefed. The Court, however, must recognize as error its holding in *Roe* that the federal courts are empowered to breach the separation of state and federal powers and thereby vitiate the protections of state law personhood or other rights subsumed therein.[25]

If this were an ordinary case, ***stare decisis*** would perhaps suffice. But on the facts, this is precisely the type of case which this Court has already recognized as being one in which ***stare decisis*** is insufficient. As this Court said in ***Edelman v. Jordan***:

> "In the words of Mr. Justice Brandeis: '***stare decisis*** is usually the wise policy, because in most matters it is more important that the applicable rule of law be settled than that it be settled right... This is commonly true even where the error is a matter of serious concern, provided correction can be had by legislation. But in cases involving the Federal Constitution, where correction through legislative action is practically impossible, this Court has often overruled its earlier decisions. The Court bows to the lessons of

25 410 U.S. at 162, 93 S.Ct. at 731, 35 L.Ed.2d at 182.

> experience and the force of better reasoning, recognizing that the process of trial and error, so fruitful in the physical sciences, is appropriate also in the judicial function.'" (citation omitted).[26]

This case established the law of ***stare decisis*** eighteen years before *Casey, supra,* was decided. Yet the Joint Opinion in *Casey* makes no mention of this point, while claiming that the Court's precedents governing the overruling of precedent did not apply in that case. ***See, Casey,*** 505 U.S. at 853-869, 112 S.Ct. at 2808-2816, 112 L.Ed.2d at 699-709.

Query, then, how this Court may have missed this point?

The quote of Justice Brandeis in ***Edelman*** comes from his famous dissent in ***Burnet v. Coronado Oil and Gas Co.***[27] We must pay close attention to the lesson which Justice Brandeis taught therein: If this Court is unwilling to reexamine its holdings of constitutional law in an appropriate case, it must very nearly invite the legislatures of the several states to legislate squarely contrary to the holdings of this Court in order to gain review of such holdings. Such interbranch disharmony is hardly in keeping with what the framers of the Constitution had in mind.

In making these statements which were quoted by this Court in ***Edelman***, Justice Brandeis dropped a footnote (footnote three, omitted from the Court's opinion in ***Edelman***) in which he cited three opinions in particular in

26 ***Edelman v. Jordan***, 415 U.S. 651, 671, n. 14, 94 S.Ct. 1347, 1359-1360, n. 14, 39 L.Ed.2d 662, 677, n. 14 (1974).
27 ***Burnet v. Coronado Oil and Gas Co.***, 285 U.S. 393, 406-408, 52 S.Ct. 443, 447-448, 76 L.Ed. 815, 823-825 (1932) (Brandeis, J., dissenting).

support of his position.[28] The first of these comes from Chief Justice Taney, nine years before ***Dred Scott:***

> "After such opinions, judicially delivered, I had supposed that question to be settled, so far as any question upon the construction of the Constitution ought to be regarded as closed by the decision of this court. I do not, however, object to the revision of it, and am quite willing that it be regarded hereafter as the law of this court, that its opinion upon the construction of the Constitution is always open to discussion when it is supposed to have been founded in error, and that its judicial authority should hereafter depend altogether on the force of the reasoning by which it is supported." ***The Passenger Cases***, 48 U.S. (7 How.) 283, 470, 12 L.Ed. 702, 781 (January Term, 1848) (Taney, C.J., dissenting).

Two other opinions (one dissent, and one for this Court itself) were also cited therein by Justice Brandeis:[29]

> "With as full respect for the authority of former decisions, as belongs, from teaching and habit, to judges trained in the common-law system of jurisprudence, we think that there may be questions touching the powers of legislative bodies, which can never be finally closed by the decisions of a court..." ***Washington University v. Rouse***, 75 U.S. (8 Wall.) 439, 444, 19 L.Ed. 498, 500 (1869) (Miller, J., dissenting).

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28 Ibid.
29 Ibid.

> "It is more important that the court should be right upon later and more elaborate consideration of the cases than consistent with previous declarations. Those doctrines only will eventually stand which bear the strictest examination, and the test of experience." ***Barden v. Northern Pacific R. Co.***, 154 U.S. 288, 322, 14 S.Ct. 1036, 1036, 38 L.Ed. 992, 1000 (1894).

Reasoned judgment[30] cannot withstand the force of such logic. On the contrary, reasoned judgment stands shoulder to shoulder with such logic to provide us with a better picture of the law.

Justice Brandeis then went on to say in his opinion,

> "The reasons why this court should refuse to follow an earlier constitutional decision which it deems erroneous are particularly strong where the question presented is one of applying... the Constitution... This is strikingly true of cases under the due process clause..."[31]

Roe itself, of course, was decided under the Due Process Clause of the **Fourteenth Amendment**.[32]

This Court can try to adjudicate this case without reexamining certain central portions of *Roe* if it wants to. But that would be like examining the forest without looking at the trees.

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30 ***See, Planned Parenthood v. Casey***, 505 U.S. 833, 849, 112 S.Ct. 2791, 2806, 120 L.Ed.2d 674, 697 (1992) (Joint Opinion).
31 285 U.S. at 410, 52 S.Ct. at 449, 76 L.Ed. at 826.
32 410 U.S. at 152-153, 93 S.Ct. at 726-727, 35 L.Ed.2d at 176-177.

We therefore ask the Court to bear in mind that the laboratory of the states[33] did not close down with the enactment of the **Fourteenth Amendment**. It is still open for business.

Let the Court now consider where we have come since *Roe*. When that case was decided, if anyone had told this Court at that time that so ghastly a procedure as is at issue here would follow in its wake, and that circuits of the Courts of Appeals would deem such practices to be shielded by *Roe*, the person sounding the alarm would either have been dismissed as a fanatic or scorned into silence.

Yet here we are. What, then? Have we lost our way, and become unsure of what we are here for? Law is to be the guardian of rights, not the extinguisher thereof.

Have we all perhaps become so numb that we can no longer feel the pain?

Things can only go from bad to worse. For given the miracles of modern medicine, can we be very far away---very far away at all---from the day when organs will be transplanted from one child in the womb to another, younger child who has already been born?

One child will be a person, invested with all the rights pertaining thereto. The donor child, however, will be... what? A zero? A nothing within the law?

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33 *See, New State Ice Co. v. Liebmann*, 285 U.S. 262, 310-311, 52 S.Ct. 371, 386-387, 76 L.Ed. 747, 771 (1932) (Brandeis, J. dissenting). *See also, Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 292, 110 S.Ct. 2841, 2859, 111 L.Ed.2d 224, 251 (1990) (O'Connor, J., concurring).

Is this Court solidly of the opinion that this would not constitute slavery? And lest this Court think that the safeguards of the law at the moment are adequate to prevent such things, what will be the case if consent to harvest fetal organs for research or transplant use is the consideration necessary for an indigent woman to obtain an abortion which she would not be able to afford otherwise? This Court has made it clear repeatedly that undue economic barriers to obtaining an abortion violate *Roe*.[34] If state law personhood for the unborn cannot be recognized, and the right to kill one's own offspring in the womb is a constitutional right, how could prohibiting the donating of fetal organs in exchange for an abortion not be an undue economic burden in at least some cases?

In the final act of The Crucible, the playwright tells how, upon the morning of the final executions authorized by the Salem witchcraft trials, the judges thereof learn of circumstances which evince that something is terribly wrong, and receive notice thereby that the whole affair to date may have been a very egregious mistake.

They expressly reject the suggestion that they should postpone the final hangings pending a thorough investigation of the calamity, however, on the dubious (but academically tenable) grounds that it would be unjust to let some go free when others have already hanged.[35] But more insidious still is the unspoken current beneath the surface---that postponing the hangings will be a public admission that the whole affair was a mistake, that they, the learned judges, had been deceived, and that the whole

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34 *See, Akron v. Akron Center For Reproductive Health*, 462 U.S. 416, 103 S.Ct. 2481, 76 L.Ed.2d 687 (1983). *See also, Planned Parenthood, Kansas City of Missouri v. Ashcroft*, 462 U.S. 476, 103 S.Ct. 2517, 76 L.Ed.2d 773 (1983).

35 Arthur Miller, The Crucible 129 (1953).

affair, including the suspension of a nearly 500 year old right to a trial by jury, was a miscarriage of justice.

The judges, having the esteem of the community as being the very guardians of a system of law which was supposed to protect against such things, could not then face the public shame and humiliation which an admission of such doubts about the trials would entail. They let the final victims hang.

Must this Court in turn be faced with a similar dilemma? May it never be so. God save this honorable Court.

This Court, in fact, has already dodged such a bullet once. Consider ***Sierra Club v. Morton,***[36] a case originally brought up to this Court along with ***Roe*** to consider questions of federal jurisdiction. In that case, three justices of this Court---Blackmun, Brennan, and Douglas---would have granted standing to trees, rocks, and rivers (and perhaps snakes, even?), though they would have denied it to the unborn.[37] ***Roe***, however, was put over for reargument.

Had ***Roe*** not been put over for reargument the next term, the two cases might actually have been decided on the same day---to the great embarrassment of this Court, we must regretfully say, particularly to the author of this Court's opinion in ***Roe***. And even today, we note, apparently none, or very few, will toll the bell for those who are

36 ***Sierra Club v. Morton,*** 405 U.S. 727, 92 S.Ct. 1361, 31 L.Ed.2d 636 (1972).
37 ***Sierra Club v. Morton,*** 405 U.S. at 755, 92 S.Ct. at 1376, 31 L.Ed.2d at 654 (1972) (Blackmun, J., dissenting); 405 U.S. at 755, 92 S.Ct. at 1376, 31 L.Ed.2d at 654 (Brennan, J., dissenting); and 405 U.S. at 741, 92 S.Ct. at 1369, 31 L.Ed.2d at 647 (Douglas, J., dissenting).

victims of a partial-birth abortion.[38]

The case that launched a thousand briefs will not soon go away. The honor of this Court is at stake. A reconsideration of those parts of ***Roe*** which gave rise to the ugly phenomenon of partial-birth abortion is not optional.

Liberty indeed finds no refuge in a jurisprudence of doubt.[39] But neither does it find a refuge in a jurisprudence of hoping that somehow or in some way the inevitable will not eventually reach the very steps of this Court.

It is therefore incumbent upon this Court to save itself from embarrassment now, and greater embarrassment to come, by recognizing that federal courts in particular have no place in declaring that the primary repository of our rights---the states---have no business legislating against such a ghastly procedure.

1.) ***Roe*** Is Not Necessary For The Protection Of Anything Except Abortion.

Roe has been cited as being necessary for the protection of certain constitutional rights.[40] Such statements, however, are not only incorrect as a matter or law, but ironically even constitute admissions adverse to the continued

38 ***See, Sierra Club v. Morton,*** 405 U.S. at 760, n. 2, 92 S.Ct. at 1378, n. 2, 31 L.Ed.2d at 657, n. 2 (1972) (Blackmun, J., dissenting).
39 ***See, Casey, supra,*** 505 U.S. 833, 112 S.Ct. 2791, 120 L.Ed.2d 674 (opening statement of the Joint Opinion).
40 ***Casey, supra,*** 505 U.S. at 857-859, 112 S.Ct. at 2810-2811, 120 L.Ed.2d at 702-703 (Joint Opinion). ***See also, Thornburgh v. American College of Obstetricians and Gynecologists,*** 476 U.S. at 778, n. 6, 106 S.Ct. at 2188, n. 6, 90 L.Ed.2d at 805, n. 6 (1986) (Stevens, J., concurring).

acceptance of *Roe*.

To say that *Roe* is necessary for the protection of a constitutional right is to say that *Roe* did not follow the law. For if *Roe* is truly necessary to reach a particular result, then it must be the case that the same force of reasoning which forms the basis of *Roe* cannot be found elsewhere in the U.S. Constitution or in the cases.

That being the case, *Roe* would have to be a creation of organic law---an organic expansion of the Constitution, at that, a power which this Court has declared it does not have even with respect to simple statutory construction or even common-law adjudication.[41]

On the other hand, if *Roe* did follow the law, then all that it purports to do to protect the liberty interests of the Constitution can also be found in those other cases which this Court has said *Roe* did follow, thereby rendering *Roe* unnecessary.[42] And happily, as it turns out, the actual liberty interests referred to in *Roe* are not even dependent upon reference to *Roe* for their recognition.[43]

2.) The First Amendment Does Not Disallow A State Recognition Of Personhood.

Perhaps the most inexplicable myth of *Roe* is that

41 *See, Willy v. Coastal Corporation*, 503 U.S. 131, 135, 112 S.Ct. 1076, 1079, 117 L.Ed.2d 280, 287 (1992). *See also, Northwest Airlines v. Transport Workers Union of America*, 451 U.S. 77, 94-95, 101 S.Ct. 1571, 1582-1583, 67 L.Ed.2d 750, 764-766 (1981).

42 *See, Casey, supra*, 505 U.S. at 852-853, 112 S.Ct. at 2807-2808, 120 L.Ed.2d at 699 (Joint Opinion).

43 *See, Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. at 287-292, 110 S.Ct. at 2856-2859, 111 L.Ed.2d at 247-251 (1990) (O'Connor, J., concurring).

somehow the **Establishment Clause of the First Amendment**[44] requires us to refuse to recognize the personhood of the unborn. If anything, however, precisely the opposite is the case.

The only way the personhood of the unborn can be unknown or unknowable is if theological or philosophical criteria are introduced into the analysis of the issue. If they are excluded---if only objective, secular (i.e. biological) criteria are employed---there can be but one answer: an unborn child is a person.

The Court in *Roe* found it significant that those trained in the respective disciplines of medicine, philosophy, and theology disagreed on this subject.[45] But in attributing significance to the views of the disciplines of philosophy and theology, this Court denied the personhood which the unborn would otherwise unquestionably be entitled to within guidelines which employ secular criteria alone. Did this Court not thereby violate its own **First Amendment** jurisprudence?[46] Certainly at a minimum, the **First Amendment** does not disallow a recognition of state law personhood.

Let us look back at this Court's history for a moment. In 1857, when *Dred Scott* was decided, the discipline of genetics did not yet exist. There was no unimpeachable biological method of ascertaining the humanity of African-

44 Congress shall make no law respecting an establishment of religion. U.S. Const. amend. I, § 1, cl. 1.

45 410 U.S. at 159, 93 S.Ct. at 730, 35 L.Ed.2d at 181.

46 *See, Lee v. Weisman*, 505 U.S. 577, 112 S.Ct. 2649, 120 L.Ed.2d 467 (1992). *See also, Lemon v. Kurtzman*, 403 U.S. 602, 91 S.Ct. 2105, 29 L.Ed.2d 745 (1971) (proscribing advancing a religious point of view or developing an unnecessary entanglement with religion).

Americans. And the Quakers were steadfastly trying to gain a recognition of our humanity.

Does this mean that our humanity was just a religious issue back then? Will this Court continue to rely on a line of reasoning in which it implicitly takes the position that this Court, in 1857, could not have recognized our own personhood as being a violation of the **First Amendment**?

As to those who argue that we must follow the **First Amendment** in adjudicating the personhood status of the unborn, we say that we agree. And even if they do then draw the conclusion that the unborn are not persons, we still hope that they keep on making those **First Amendment** arguments. Because those arguments support our conclusion, not theirs.

II. A Partial Breech Birth Is Not A Healthy Thing.

One thing above all others on the facts stands out in our minds. When a mother near term hears that her baby is properly positioned, head-first, for its birth, is she joyous, or full of worry instead? And if she hears that her child is in a position for a breech birth, does this lighten her heart, or bring her fear?

How it could be the case that deliberately setting the child into a breech-birth position would ever be of help to the mother is something which remains a mystery to us. How it could ever possibly be necessary to actually save the life of the mother, when a Caesarean section birth or a normal vaginal delivery is an option, is truly puzzling.

III. Judge Samuel Sewall Of The Salem Witchcraft Trials Set An Example For Us.

In 1697, a humbled, contrite man handed a note to his pastor at a service in South Church in Boston, Massachusetts. Judge Samuel Sewall, one of the jurists of the Salem witchcraft trials five years earlier, then stood and listened while his pastor, Samuel Willard, read aloud his Bill of Contrition, which read:

> "Samuel Sewall, sensible of the reiterated strokes of God upon himself and family; and being sensible, that as to the Guilt contracted, upon the opening of the late Commission of Oyer and Terminer ["to hear and decide"] at Salem... Desires to take the Blame and Shame of it, Asking pardon of Men, And especially desiring prayers that God, who has an Unlimited Authority, would pardon that Sin and all other his Sins; personal and Relative: And according to his infinite Benignity, and Soveraignty, Not Visit the Sin of him, or of any other, upon himself or any of his, nor upon the Land: But that He would powerfully defend him against all Temptations to Sin, for the future, and vouchsafe him the Efficacious, Saving conduct of his Word and Spirit."

Judge Sewall then bowed and retook his seat.[47]

He didn't have to do that. He had only been doing his duty in 1692 as he saw it, and in any event he was immune from prosecution. But Judge Sewall's most recent diary

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47 T.B. Strandness, Samuel Sewall: A Puritan Portrait 75-76 (1967). 1 M. Halsey Thomas, The Diary of Samuel Sewall 367 (1973). Ola Elizabeth Winslow, Samuel Sewall of Boston 134-135 (1964).

entries prior to his noting of his Bill of Contrition make mention of the fact that he had recently buried his abortive (i.e. miscarried) son, and that he and his wife grieved the losses of their "little daughter and other children" which they had suffered over time.[48]

Judge Sewall felt that he had to do this in order to make all things right, as these afflictions were, in his view, "the reiterated strokes of God upon himself and family"[49] in punishment for his role at the Salem trials.

Arising from the ashes of sin and despair which his participation in that tribunal wrought upon him, however, he then went on to become an early outspoken opponent of slavery, publishing a book denouncing that institution three years later, and warning therein that any nation which would suffer the evils of such an institution to flourish unchecked in the land must surely suffer God's wrath in some great calamity to come.[50]

CONCLUSION

The judgment of the United States Court of Appeals for the Eighth Circuit must be reversed.

Respectfully submitted,

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48 1 M. Halsey Thomas, The Diary of Samuel Sewall 366 (1973).
49 1 M. Halsey Thomas, The Diary of Samuel Sewall 367 (1973).
50 Samuel Sewall, The Selling of Joseph, A Memorial (1700). This was reprinted by The University of Massachusetts Press in 1969.

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No. 99-830

In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al., *Petitioners*,

v.

LEROY CARHART, M.D., *Respondent*.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

Brief of Amici Curiae National Right to Life Committee, Christian Legal Society, Concerned Women for America, The Southern Center for Law and Ethics, and Focus on the Family in Support of Petitioners

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INTEREST OF AMICI CURIAE[1]

The **National Right to Life Committee**, Inc. (NRLC) is a nonprofit organization whose purpose it to promote respect for the worth and dignity of all human life from conception to natural death. NRLC is comprised of a Board of Directors representing 51 state affiliate organizations and about 3,000 local chapters made up of individuals from every race, denomination, ethnic background, and political belief. It engages in various political, legislative, legal, and educational activities to protect and promote the concept of the sanctity of innocent human life.

The **Christian Legal Society**, founded in 1961, is a nonprofit interdenominational association of over 4,000 Christian attorneys, law students, judges, and law professors with chapters in nearly every state and at over 140 accredited law schools. Since 1975, the Society's legal advocacy and information division, the Center for Law and Religious Freedom, has worked for the protection of religious belief and practice, as well as for the autonomy from the government of religion and religious organizations, in the Supreme Court of the United States and in state and federal courts throughout this nation. Further, the Society has a keen interest in promoting the sanctity of human life.

Concerned Women for America (CWA) was founded in 1979 by Beverly LaHaye to speak for women who believed that feminists did not speak for all women. Today, Concerned

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[1]**Rule 37.6**: Amici Curiae disclose that (1) no counsel for a party authored this brief in whole or in part and (2) no monetary contribution was made to the preparation or submission of this brief by any person or entity, other than the Amici Curiae, their members, or their counsel. **Rule 37.3(a)**: Petitioners and Respondent consented to the filing of this brief. Consent letters have been provided to the Clerk.

Women for America – with members in all 50 states – is the largest public policy women's organization in the Nation. Numbering over 500,000 nationally, CWA members are active at all levels of policymaking. Its membership includes women and men of all ages and from all walks of life and affiliation with multiple political parties. CWA promotes traditional values and strong families through education and legislation, focusing on six core issues. The sanctity of life is central to the work and mission of CWA.

The **Southern Center for Law and Ethics** is a non-profit, publicly funded, tax-exempt corporation founded in 1985 and based in Birmingham, Alabama. The Center furnishes legal counsel and files amicus curiae briefs on a variety of issues, including constitutional and reproductive issues. The Center has been particularly active, through litigation and scholarship, in seeking to develop and promote a proper understanding of the constitutional right of privacy/substantive due process. The Center submitted amicus curiae briefs in this Court in *Webster v. Reproductive Health Services* (1989), *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992), and *Washington v. Glucksberg* (1997). The Center is particularly concerned with the treatment of partial-birth abortion within the context of the Court's developing privacy/substantive due process jurisprudence.

Focus on the Family is a California Nonprofit Religious Corporation committed to strengthening the family in the United States and abroad. The president of Focus on the Family, James C. Dobson, Ph.D., is a child psychologist who has written extensively on child rearing and family relations. Dr. Dobson hosts, and Focus on the Family distributes, a daily radio broadcast about family issues that reaches approximately 1.7 million listeners each day in the United States, Canada and around the world. Focus on the Family publishes and distributes

Focus on the Family magazine and other literature that is received by more than 2 million households each month. Focus on the Family has actively promoted the sanctity of human life and has appeared in numerous cases before this Court as *amicus curiae*. Focus on the Family actively promotes public policies which provide protection for infants, children and women and is specifically concerned about the trend in American life toward the acceptance of infanticide

SUMMARY OF THE ARGUMENT

The Nebraska partial-birth abortion statute, properly construed, bans only intentional killing of a fetus after intentionally delivering the body of the fetus, except for the fetal head, into the vagina for the purpose of killing the fetus. As such, the Nebraska ban does not directly implicate the abortion liberty recognized by the precedents of this Court.

The policy considerations that formed the basis for this Court's reaffirmance of the right to decide to terminate pregnancy do not apply to partial-birth abortion bans. These statutes prohibit killing the fetus while in the process of birth although alternative means of terminating pregnancy are available. Americans do not rely upon access to such a procedure to conduct their social or economic lives. Subjecting partial-birth bans to rigid scrutiny would signal a return to the abortion jurisprudence that preceded *Planned Parenthood v. Casey*. It would be contrary to the very considerations of stare decisis and concern for judicial integrity that *Casey* represented.

The *Roe/Casey* right does not include the right to production of a dead fetus or to determine the method of pregnancy termination. When means exist to safely terminate pregnancy without directly killing the fetus, the State might thus prohibit the killing act. Here, safe alternative means of pregnancy termination are available that do not involve feticide, so the

Nebraska statute does not place a substantial obstacle in the path of women seeking to terminate pregnancy.

The State's interest in protection of the fetus increases and the woman's interest in pregnancy termination diminishes as the fetus approaches birth as it leaves the maternal body. The new balance struck between these competing rights and interests in the context of partial-birth abortion warrants greater regulation by the State in furtherance of its interest in protection of fetal life.

To the extent that partial-birth abortion bans implicate the right to decide to terminate pregnancy, they nevertheless do not impose an undue burden on the exercise of this right. In this facial attack, the Nebraska statute survives under the standard of *United States v. Salerno* because there are obvious circumstances in which the statute has constitutional applications. The Nebraska ban likewise survives under the undue burden test announced by *Planned Parenthood v. Casey* because it does not form a substantial obstacle to large fraction of women for whom it is relevant. At most, 1/19th to 2/19ths of Respondent Carhart's patients could conceivably be blocked from deciding to secure abortion under the Nebraska ban.

A generalized exception that would permit performance of partial-birth abortion for maternal health reasons is not required. The Nebraska statute does not forbid pregnancy termination for any reason, but only the use of a certain method of pregnancy termination. Since safe alternative methods are available, women's health interests are not compromised by the Nebraska ban. Certainly, there is no significant maternal health advantage to performance of partial-birth abortion. This Court's precedents warrant state regulation to protect fetal life when, as here, there is no substantial threat to maternal health entailed.

ARGUMENT

I. The Right to Decide to Terminate Pregnancy Does Not Include a Right to Secure a Partial-Birth Abortion.

Properly construed, the Nebraska partial-birth abortion statute bans only intentional killing of a fetus after intentionally delivering the body of the fetus except for the fetal head into the vagina for the purpose of killing the fetus.[2] Amici argue that the feticidal conduct prohibited by the Nebraska ban does not directly implicate the abortion liberty recognized in *Roe v. Wade*, 410 U.S. 133 (1993), and modified in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992).

As this Court has stressed, the liberty recognized by *Roe* and *Casey* is the woman's "freedom to decide whether to terminate her pregnancy." *Casey*, 505 U.S. at 874, quoting *Maher v. Roe*, 432 U.S. 464, 473-474 (1977). "Roe did not declare an unqualified 'constitutional right to abortion.'" *Id.* The woman's right is not "absolute and . . . she is [not] entitled to terminate her pregnancy at whatever time, in whatever way,

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[2]Amici adopt the construction of Neb. Rev. Stat. §§ 28-326(9), -328(1)-(4) (Supp. 1998), the Nebraska partial-birth abortion ban, of the Attorney General of the State of Nebraska, which requires: 1) intentional delivery of the body of the fetus except for the fetal head into the vagina for the purpose of killing the child, 2) killing the fetus with specific intent to do so after delivery into the vagina, and 3) completion of the delivery.

Under this construction, the fetus that presents head-first is never subject to the statute since it applies only to the fetus that has emerged from the uterus feet-first and whose head remains lodged in the uterus. Similarly, it does not apply to the conventional D&E procedure since the D&E involves dismemberment before the fetus might emerge feet-first from the uterus to a head-lodged position.

and for whatever reason she alone chooses." *Roe*, 410 U.S. at 153. Laws regulating pregnancy termination should be upheld "which in no real sense deprived the woman of the ultimate decision," *Casey*, 505 U.S. at 875, and "if they are not a substantial obstacle to the woman's exercise of the right to choose." *Id.* at 877.

The Nebraska ban prohibits the use of a certain method of abortion; it does not forbid the woman to decide or to effectuate the decision to terminate pregnancy. Nebraska forbids intentional killing of the fetus in the process of pregnancy termination; it does not prohibit termination of the pregnancy. Moreover, none of the considerations that led this Court to affirm the central holding of *Roe* in *Casey* are present here: Upholding a ban on partial-birth abortion would not threaten jurisprudential disrepute or undercut social and personal assumptions based on recognition of right to decide to terminate pregnancy.

A. *A Ban on Partial-Birth Abortion Does Not Implicate the Policy Considerations Underlying this Court's Decision in Planned Parenthood v. Casey.*

Bans on partial-birth abortion, such as the Nebraska statute now before this Court, do not directly implicate the central holding of *Roe v. Wade*, reaffirmed in *Planned Parenthood v. Casey*, namely, a woman's right to decide whether to terminate a pregnancy.

Partial-birth abortion laws prohibit one type of abortion procedure, while allowing other safe procedures to be performed with impugnity. They forbid conduct directly intended to kill the fetus, although killing the fetus is unnecessary in order to achieve pregnancy termination. They involve killing a fetus near the completion of the process of pregnancy termination, where the fetal head is lodged in the uterus and the remainder of the fetal body is in the birth canal or outside the maternal body.

If the joint opinion in *Casey* is controlling, such limited regulation of abortion practice should simply not be subjected to the relentless scrutiny to which pre-*Casey* regulations were subjected even when they presented no substantial obstacle to effectuation of a decision to abort. *See* 505 U.S. at 875. The *stare decisis* considerations and concerns over the reputation of judiciary expressed in *Casey* militate against abandoning *Casey*'s more balanced, nuanced approach to abortion jurisprudence in favor of a return to the absolutist scrutiny that preceded *Casey* and urged by the Respondent here.

Under the Respondent's theories, the right to decide to terminate a pregnancy includes a right to production of a dead fetus. The abortion choice includes not only the right to terminate pregnancy, but the right to do so in any manner one chooses. In Respondent's view, the State's substantial and

profound interest in the protection of fetal life even in the process of birth must always yield to any asserted interest in maternal health, no matter how speculative and remote. Legislative determinations of fact must be discounted, argues Respondent, in favor of the mere discretionary judgments of individual physicians performing abortion.

This radical, ideologically driven approach is definitely at war with the moderating approach promised by *Casey*, which abandoned the rigid verities that attended the trimester system, including its complete devaluation of the State's interest in fetal life prior to viability. *See* 505 U.S. at 875-76.

Upholding partial-birth abortion bans would entail none of the serious issues of reliance that counseled against reversal of *Roe* in *Casey*. As the Court noted:

> [F]or two decades of economic and social developments, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion . . . The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives. [505 U.S. at 856.]

On the present facts, it cannot be seriously argued that "people have organized their thinking and living" (*id.*) around the availability of partial-birth abortion. To the contrary, it is a marginal and controversial procedure unnecessary to abortion practice. The balance *Casey* struck between competing interests at stake in abortion should not be sacrificed for the sake of a procedure that lies nowhere near the core considerations that prompted recognition of the abortion liberty or that argued against reversal of *Roe*.

Nearly three-fifths of the States have banned partial-birth abortion,[3] and Congress has twice voted to ban the procedure with two-thirds majorities in the House and near two-thirds majorities in the Senate. Cong. Rec. S18228, roll call #596 (Dec. 7, 1995); Cong. Rec. H2929, roll call #94 (Mar. 28, 1996); Cong. Rec. H3338-3339, H. Doc. 104-198 (Apr. 10, 1996). It cannot be assumed that the States and Congress would so proceed if women or the population as a whole relied on the availability of the procedure to any significant degree in pursuing their social and personal expectations. To the contrary, such

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[3]Twenty-seven states have enacted statutes substantially similar to Nebraska's: Ala. Code §§ 26-23-1, 26-23-3 to 26-23-4 (1998); Alaska Stat. §§ 18.16.050 (Michie 1998); Ariz. Rev Stat. Ann. 13.3603.01 (West 1997); Ark. Code Ann. §§ 5-61-201 to 5-61-203 (Michie 1997); Fla. Stat. Ann. §§ 390.11, 390.0111 (West 1998); Ga. Code Ann. § 16-12-144 (1998); Idaho Code § 18-613 (1998); 720 Ill. Comp. Stat. 513/5-5, 513/5-10, 513/5-20 (West 1998); Ind. Code Ann. §§ 16-18-2-267.5, 16-34-2-1(b), 16-34-2-7(d) (Michie 1998); Iowa Code § 707.8A (1998); Ky. Rev. Stat. §§ 311.595(3), 311.720, 311.990(11) (Michie 1998); La. Rev. Stat. Ann. § 32.9 (West 1998); Michigan Senate Bill 546, P.A. 107 (1999) (signed July 7, 1999) (eff. date 90 days after closing of 1999 legislative session); Miss. Code Ann. §§ 411-41-71, 411-41-73 (1998); Missouri Senate Substitute No. 3 for House Bills Nos. 427, 40, 196 and 404 (1999), to be codified at Mo. Rev. Stat. § 565.300 et seq.; Mont. Code Ann. § 50-20-401, as amended by 1999 Mont Laws 479; Neb. Rev. Stat. Ann. §§ 28-326, 28-328, 71-148(15) (Michie 1997); N.J. Stat. Ann. §§ 2A:65A-5 to -7 (West 1997); N.D. Cent. Code §§ 14-02.6-01 to 14-02.6-03; Okla. Stat. tit. 21, § 684 (1998); R.I. Gen. Laws §§ 23-4.12-1, 23-4.12-2, 23-4.12-3, 23-4.12-4 (1998); S.C. Code Ann. §§ 44-41-85, 16-1-90(F) (Law Co-op 1997); S.D. Codified Laws §§ 34-23A, 34-23A-32 (Michie 1998); Tenn. Code Ann. § 39-15-209 (1997); Va. Code Ann. § 18.2-74.2 (Michie 1998); Wis. Stat. §§ 895.038, 940.16 (1997); W.Va. Code §§ 33-42-3, 33-42-8 (1998). Three other states have attempted to target intact D&X in statutes using different language. *See* Kansas Stat. Ann. § 65-6721 (1998); Ohio Rev. Code §§ 2919.15 to 2919.19, 2307.51, 2305.11(C) (1997); Utah Code Ann. § 76-7-310.5 (1999).

super majorities support the proposition that Americans do not even regard the partial-birth procedure as within the realm of what they consider to be "abortion." They perceive it to fall outside the scope of the abortion choice recognized in *Roe* and reaffirmed in *Casey*.

This Court cannot treat partial-birth abortion bans as though they jeopardized the abortion liberty to the same degree as actual prohibitions on the performance of any abortion. To do so would effectively label *Casey* as an aberration in abortion jurisprudence rather than its leading precedent. Such a retreat would be perceived as a "statement that [the] prior decision [in *Casey*] was wrong" and "would be taken as evidence that justifiable reexamination of principle had given way to drives for particular results in the short term." 505 U.S. at 806. The Court's refusal to reverse *Roe* was based in significant part upon the concern that this "would subvert the Court's legitimacy beyond any serious question." *Id.* at 807. The Court's legitimacy would be likewise jeopardized should it now discard *Casey*'s more balanced approach in favor of a concept of the abortion liberty that embraces such extreme procedures as partial-birth abortion.

B. *The Right to Decide to Terminate a Pregnancy Does Not Encompass the Right to Production of a Dead Fetus.*

Respondent's claim that a ban on partial-birth abortion represents an undue burden on the abortion choice assumes that this liberty includes both the right to terminate the pregnancy of the woman and the right to kill the fetus. As the Respondent, Dr. Carhart, stated under cross-examination,

> My intent in every abortion that I have ever done is to kill the fetus and to terminate the pregnancy. It think that's the specific intent that I [have when I] enter the room when I go to talk to the patient. That's what she's asking to do, and that's what I'm there to do, and I do what I do to get that done.

J.A. 100.[4] Effectuation of Dr. Carhart's intent to terminate pregnancy is protected by *Roe* and *Casey*. Effectuation of his intent to kill the fetus is not.

Undoubtedly, fetal death is the likely outcome of most efficiently performed abortions, and there may be no other way to complete most abortions except in a manner that involves fetal death.

However, a guarantee of a right to "terminate pregnancy" – the right to empty the womb – does not of necessity include a right to feticide. The State maintains a "substantial" and "profound" interest in the protection of fetal life throughout gestation.[5] *Casey*, 505 U.S. at 876, 878. Plainly, the State may

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[4]References to the Supplemental Appendix to the Petition For Writ of Certiorari will noted ad "Supp. App. ___." References to the Joint Appendix will be noted as "J.A. ___."

regulate abortion practices to protect this interest, at least to the extent that the state action involved does not effectively prohibit the woman from safely securing an abortion. The State may proscribe killing the fetus if pregnancy termination may be safely accomplished without a killing act.

This distinction between a "right to terminate pregnancy" that is legitimate under this Court's decisions and an illegitimate "right to feticide" is at stake in evaluating the constitutionality of Nebraska's partial-birth abortion ban. As construed by the State, Nebraska's statute prohibits only direct, separate, and intentional feticidal conduct – typically, crushing the fetal skull or evacuating the fetal brain – after the fetus has been partially delivered to effectuate this purpose. The statute does not prohibit termination of pregnancy, but termination of fetal life. As such, it does not directly implicate the right to decide to terminate pregnancy recognized in *Roe* or *Casey*.

Nebraska has determined to assert its interest in protection of fetal life once the fetus has been caused to emerge from the uterus to the degree that only the fetal head remains within. The decision was made that, under these circumstances, the process

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[5]Amici note that the Nebraska statute's prohibition of a feticidal act applies without regard to whether the fetus is deemed "viable" – capable of survival outside the maternal body. Pregnancy termination of a nonviable child will necessarily result in death. However, the conduct that the Nebraska statute proscribes is a separate and intervening intentional killing act during the course of pregnancy termination, not pregnancy termination itself, even if it must necessarily lead to death.

The Nebraska statute is rationally related to the State's interest in protection of fetal life regardless whether the fetus is deemed viable. A nonviable fetus is terminally ill if pregnancy is terminated. But the State has an interest in protecting against intentional killing acts directed toward human beings – adult, child, or fetus – whether they are terminally ill or not.

of birth has so far progressed that feticidal conduct is no longer warranted or necessary to effectuate any legitimate interest in pregnancy termination. Pregnancy may continue to be terminated and the child delivered. But any killing act in the interim is proscribed.

Because the *Roe*/*Casey* right does not include a right to feticide, the Respondent can impugn the constitutionality of the Nebraska ban if and only if it somehow operates to effectively block a woman's decision to terminate pregnancy – to rid her body of the fetus. But the record of this case is devoid of any proof that a killing act – for example, collapsing of the skull or brain evacuation – is in any sense necessary to effectuation of a decision to terminate pregnancy once the fetus has been delivered to the extent that only the fetal head remains lodged in the uterus.

The Respondent testifies that, in the interests of efficiency and maternal health, he always attempts to deliver the fetus intact during the course of the post-first trimester abortions he performs. *Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1105 (D. Neb. 1998) (Supp. App. 15).[6] Either by design or accident,

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[6]As Dr. Martin Haskell, initiator of the partial-birth abortion procedure stated,

> I could put dilapan in for four or five days and say I'm doing a D&E procedure and the fetus could just fall out. But that's not really the point. The point here is you're attempting to do an abortion. And that's the goal of your work, is to complete an abortion. Not to see how do I manipulate the situation so that I get a live birth instead.

The Partial-Birth Abortion Ban Act of 1995: Hearing on H.R. 1833 Before the Senate Comm. on the Judiciary, 104th Cong. (Nov. 17, 1995) at 22-24 (Letter from Barbara Bolsen, Editor of *American Medical News*, to the Hon. Charles T. Canady, Chairman, Subcomm. on the Constitution, Comm. on

(continued...)

however, the fetal head sometimes becomes lodged in the uterus as the rest of the fetal body emerges into the birth canal during the course of some abortions.

The Nebraska statute does not punish a killing act if the head should lodge by accident. Rather, the statute provides that the fetus must intentionally be delivered into this position for the purpose of killing for liability to attach. The Respondent can only be held liable if he purposely delivered the fetus into such a position for the sake of killing. This cannot in any way be necessary to effectuate a mere decision to terminate pregnancy.

Nothing in the record demonstrates that intentional delivery of a fetus into a head-lodged, footling breech position for the purpose of then killing the fetus in any way serves maternal health interests. The record suggests only that delivery of the fetus intact might have some advantage to maternal health. *Stenberg*, 11 F. Supp. 2d at 1107 (Supp. App. 20). But delivery of the fetus intact does not necessarily entail killing the fetus by collapsing the fetal skull or extracting the fetal brain. Nothing in the record suggests that it would be impossible to mechanically or chemically dilate the cervix further so that the fetal head might emerge or be delivered without crushing or evacuation, thereby completing pregnancy termination without resort to a feticidal act.[7] Even when the fetus has hydrocephalus, the size

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[6](...continued)
the Judiciary) (July 11, 1995) (attaching transcript of interview with Dr. Haskell from which quotation was taken)).

[7]*See* Combined Memorandum of Respondents [on Petition for Writ of Certiorari], *Planned Parenthood v. Wisconsin*, Nos. 99-1156 and 99-1177, 23a (¶ 132 of Amended Stipulation of Facts) (cervical relaxants can be used to free lodged head of partially-born child); J.A. 60 (Dr. Carhart: "I'm sure you could use more dilation, and you could remove them all (continued...)

of the fetal head can be reduced by cephalocentesis and the skull gently decompressed so that the fetus might be delivered without crushing the skull or evacuating the brain.[8]

Performance of the D&X or D&E abortion always entails purposeful dilation of the maternal cervix. At most, the record suggests only that further dilation of the cervix in order to deliver the fetal head without crushing or evacuation may pose some indeterminate risk of future cervical incompetence to the woman. J.A. 49. A possible implication is that footling breech delivery of the fetus into a head-lodged position followed by brain extraction or skull crushing would represent some relative health advantage to the woman.

However, the Respondent himself testifies about the dangers posed by potential fetal bone fragments to the woman. J.A. 47. Crushing the skull entails just such risks. He testified that the presence of fetal blood and especially brain tissue in the uterus presents the serious risks to the woman if these tissues should be absorbed into the woman's blood through the uterus. J.A. 47-50. Crushing the fetal skull would entail these risks.

Thus, whatever supposed health advantage is gained by delivering the fetus into the footling breech, head-lodged position for the purpose of killing the fetus without sufficient dilation to deliver the fetal head is balanced by the risks entailed

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[7](...continued)
intact if that were your goal.").

[8]Dr. Boehm also testified that where a fetus has severe hydrocephaly, causing the head to be too large to pass through the cervix, an ultrasound cephalocentesis procedure could be used to "drain the ventricles of the amniotic fluid to allow the head to slip through the cervix." J.A. 700-03. Dr. Boehm specifically testified that "We don't try to aspirate intra-cranial cerebral matter or brain matter." J.A. 702-03.

in performing the procedures necessary to kill the fetus. Certainly, the Nebraska legislature might conclude, in view of the balance of risks and Nebraska's profound and substantial interest in protection of fetal life, that forbidding a killing act when the fetal head is intentionally lodged in the uterus represents no *substantial* obstacle to effectively terminating a pregnancy.

Because the *Roe/Casey* right embraces only effectuation of decisions to terminate pregnancy, it protects only feticidal acts necessary to terminate pregnancy. The claim that crushing or evacuating the skull of a fetus purposely delivered into a head-only position in the uterus falls in any direct or meaningful way under the mantle of constitutional protection would stretch abortion jurisprudence well beyond the more reasonable boundaries that *Casey* insisted should apply. "The very notion that the State has a substantial interest in potential life leads to the conclusion that not all regulations must be deemed unwarranted." *Casey*, 505 U.S. at 876. Unless this Court is prepared to embrace a concept of the abortion liberty that includes a right to feticide, it should deem a prohibition on partial-birth abortion beyond the purview of right secured in *Roe* and *Casey*.

C. *The Right to Decide to Terminate Pregnancy Does Not Encompass the Right to Determine the Method by Which Pregnancy Is Terminated.*

The Nebraska partial-birth abortion statute does not prohibit pregnancy termination; it prohibits only use of a method of abortion that involves killing a child in the process of birth. The Nebraska statute could only effectively prohibit pregnancy termination if killing the fetus were necessary to safely perform pregnancy terminations in which the fetal head remains purposely lodged in the uterus while the rest of the fetal body is in the birth canal or if other alternative procedures were not

available. As Amici have shown, killing the fetus delivered in a head-lodged, breach position is neither necessary nor desirable. Moreover, it is uncontroverted that other safe, alternative methods of abortion are available – induction and conventional D&E procedures. Under no circumstance does the Nebraska statute represent an absolute obstacle to any pregnancy termination.

Any claim that the statute represents any obstacle at all is necessarily based on the notion that the D&X is always or sometimes safer than the D&E or induction procedures. Petitioners convincingly demonstrate that there is no competent, much less compelling, evidence that this is the case.

In this regard, the present case is easily distinguishable from the holding in *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 75-79 (1976), in which this Court held a prohibition on the use of saline amniocentesis abortion unconstitutional because safe, alternative abortion procedures were not readily available. Here, equally safe conventional D&E and induction procedures are available, and, where there is a breech presentation of the fetus, the fetus may be delivered without the killing act that the Nebraska statute proscribes.

The self-serving nature of the Respondent's claim that the D&X is necessary for maternal safety is exposed by the fact that the Respondent does not himself perform the D&X procedure except by default.

> Carhart does not intentionally convert the fetus to a footling breech; that is, he takes the fetus as he finds it. If the fetus presents feet first, Carhart will do a D&X. If, on the other hand, the fetus dues not present feet first, Carhart will do a D&E.

Stenberg, 11 F. Supp. 2d at 1121 (Supp. App. 59). Dr. Carhart might convert the fetus to a footling breech if the fetus lies in a

traverse or side-ways presentation, although he does not testify that he is more or less likely to convert the fetus to a feet-first or head-first position. J.A. 100. Yet if Dr. Carhart truly believed that the intact D&X procedure served maternal health interests, then he would attempt to manipulate the fetus into a footling breech position in every instance in which the fetus presents head-first or side-ways. (Indeed, if the trial court's finding that D&X is safer than D&E is to be believed, then it would be malpractice to fail to attempt to manipulate the fetus to a footling breech.) Obviously, it would make no constitutional sense to strike down the Nebraska statute because it precludes Dr. Carhart from using D&X as the safest procedure when Dr. Carhart does not himself use an intact D&X procedure except when convenient.

Respondent's argument against the Nebraska statute amounts to the erroneous assertion that the Constitution authorizes him to perform abortion in any manner he chooses so long as he can summon up some asserted maternal health benefit in doing so, no matter how speculative or pretextual. In the face of a legislative determination that equally safe alternative procedures are available, such a rule would eviscerate the conclusion of this Court that not all regulation of abortion should be deemed unwarranted. *Casey*, 505 U.S. at 876.

D. *In Balancing an Enhanced State Interest in Protection of the Unborn Child in the Process of Birth Against a Diminished Interest in Pregnancy Termination, Nebraska's Partial-Birth Abortion Ban Does Not Unduly Burden Any Abortion Liberty.*

In *Casey*, this Court abandoned the trimester scheme it had adopted in *Roe* because it "undervalue[d] the State's interest in the potential life within the woman. . . . The very notion that the State has a substantial interest in potential life leads to the

conclusion that not all regulations must be deemed unwarranted." 505 U.S. at 875-76. Thus, the Court held that abortion regulations should not be subject to "strict scrutiny" at any time of pregnancy, but instead should be found to improperly interfere with the abortion liberty only if they "unduly burden" the decision to seek abortion. *Id.* at 876-77. A state regulation is unduly burdensome and, thus, unconstitutional only if it "has the purpose or effect of placing a substantial obstacle [to] seeking an abortion . . . ." *Id.* at 887. Moreover, a regulation must "operate as a substantial obstacle to a woman's choice to undergo an abortion" in at least a "large fraction of the cases in which [the regulation] is relevant" in order to constitute an undue burden. *Id.* at 895.

A law that proscribes intentional killing of partially born children should not implicate the abortion right at all. But even if a diminished abortion liberty is tangentially implicated by Nebraska's statute, the statute does not create a substantial obstacle to the exercise of any supposed right to terminate pregnancy.

First, the Nebraska statute does not prohibit termination of pregnancy, but prohibits killing the child who is in the process of delivery and potential live birth. Even if the prohibition affects the manner in which pregnancy might be legally terminated, its impact on the abortion liberty is neither direct nor absolute, but indirect and incidental. Since pregnancy has already been at least substantially terminated before the Nebraska statute's prohibition can apply because the child has been delivered into the birth canal, the force of any abortion liberty asserted is dissipated.

Put another way, the strength of any claim to a right to terminate a pregnancy logically diminishes as a living child proceeds from the body of the mother. As the *Casey* Court observed, "in fairness," "a woman who fails to act before [fetal] viability has consented to the State's intervention on behalf of

the developing child." 505 U.S. at 870. Similarly, the woman who fails to act before the emergence of the fetus from her body has likewise consented to the State's intervention on behalf of the emerging child.

Second, the already substantial interest that the State maintains in the fetus increases as the child emerges from the body of the mother, as the child approaches the unquestioned status of a legal person under the law upon completion of live birth.

The Nebraska statute applies as the asserted abortion liberty wanes and as the State's interest in protection of the child in the process of birth waxes. Thus, in the relevant context of a partial-birth abortion, the enhanced state interest in protection of the child outweighs in the balance any diminished abortion liberty at stake in the procedure. From this perspective, any burden that the Act places on the abortion choice is neither substantial nor "undue," but represents legitimate state action in furtherance of a growing state interest in the protection of children as they proceed toward full legal personhood upon live birth.

III. The Nebraska Partial-Birth Abortion Ban Does Not Impose an Undue Burden on the Right to Decide to Terminate a Pregnancy.

Even assuming arguendo that the Nebraska partial-birth abortion ban genuinely implicates the right to decide to terminate pregnancy, it is constitutional unless it imposes an "undue burden" on the central right recognized in *Roe v. Wade*. *Casey*, 505 U.S. at 878. "An undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before viability." *Id.*

The purpose of the Nebraska statute is to proscribe unnecessary killing of a child in the process of birth, not to prevent a woman from effectuating a decision to terminate pregnancy. The effect of the statute is to compel the use of alternative techniques to the D&X, not to block the decision to abort. It can be understood to substantially burden a decision to terminate pregnancy only if it compels women to choose relatively unsafe abortion methods as the price of choosing abortion at all.

As Amici and the Petitioners have shown, however, there is no clear evidence that performance of the D&X procedure safer than other available techniques. Even if arguendo there were individual cases in which the D&X represents a significant maternal health advantage, this would warrant only declaring the Nebraska statute unconstitutional as applied to such circumstance. It would not warrant striking down the statute on the basis of a facial attack or as applied to all circumstances to which it applies.

A. *Nebraska's Ban Survives Facial Attack Under Both the* Salerno *"No Set of Circumstances" Rule and the* Casey *"Large Fraction" Rule.*

Although Respondent brought a facial attack against the Nebraska statute, the trial court declined to rule on this basis, holding instead that the statute was unconstitutional as applied to Dr. Carhart and his patients (and similarly situated persons).[9] *Stenberg*, 11 F. Supp. 2d at 1119-21 (Supp. App. 53-57). There seems no meaningful distinction between the trial court's "as applied" declaration of unconstitutionality and a facial declaration, however, since the trial court appears to hold that there is no circumstance in which the Nebraska statute may have a constitutional application. The Court of Appeals held the Nebraska statute facially unconstitutional on vagueness grounds.

When the Nebraska statute is properly construed and thereby not void for vagueness, it would be facially unconstitutional under *United States v. Salerno*, 481 U.S. 739, 745 (1987), only if there is "no set of circumstances" in which it might have a constitutional application. Under this standard, the Respondent cannot succeed because the statute plainly has some constitutional applications, e.g., in proscribing D&X abortions performed on viable fetuses where there is no health advantage or other indication for doing so.

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[9]Because the Respondent did not bring a class action, the trial court presumably reached persons "similarly situated" to Dr. Carhart's patients on the basis of Dr. Carhart's third-party representation of prospective patients. On the basis of this theory, however, relief should not have been granted to all persons similarly situated to Dr. Carhart's patients, but only to Dr. Carhart's present and future patients seeking abortion. Otherwise, the trial court's grant of relief amounts to a holding that the Nebraska statute is facially unconstitutional since it would apply to any person seeking D&X abortion.

Whether the *Salerno* standard continues to apply to abortion litigation is a matter of some dispute on this Court and among the Courts of Appeals. However, even if the *Salerno* standard is replaced with the "undue burden" test applied by this Court in *Casey*, the Nebraska partial-birth abortion ban passes scrutiny.

In determining whether a spousal notice to abortion law facially created an undue burden on the decision to abort, this Court held that outcome depended on whether the law represented a substantial obstacle to a choice for abortion for a "large fraction" of women for whom the law is relevant. *Casey*, 505 U.S. at 895. In the context of a spousal notice provision, the relevant class for whom the law was relevant included "married women seeking abortions who do not wish to notify their husbands of their intentions and who do not qualify for one of the statutory exceptions to the notice requirement." *Id.* Because this Court held that a large fraction of women in this class would be effectively precluded from choosing abortion by the spousal notice requirement, it was deemed an undue burden.

By analogy, the controlling class in the present case is that of women seeking partial-birth abortions unnecessary to save their lives. Is a "large fraction" of this class effectively precluded from securing abortion as the result of the Nebrasaka ban? Clearly, no member of this class is actually precluded from securing abortion so long as alternative procedures remain available, as they are. At most, members of this class might claim that they are precluded from choosing the safest or most convenient abortion technique, not from choosing abortion at all.

Petitioners have demonstrated that there is no competent evidence sufficient to override the legislative determination that D&E and inductions procedures are as safe as intact D&X. Certainly, the record does not demonstrate that any health

advantage of the intact D&X is sufficient to constitute a *substantial* obstacle to the performance of any abortion for a *large fraction* of women seeking partial-birth abortions.

The insubstantial impact that the Nebraska statute has on effectuation of decisions to terminate pregnancy is illustrated by Dr. Carhart's own practice. Dr. Carhart will only attempt to perform D&X on members of the class of his patients seeking abortion when the fetus presents in a footling breech position. *Stenberg*, 11 F. Supp. 2d at 1121 (Supp. App. 58-59). Otherwise, he will perform a D&E. *Id.* Dr. Carhart performs the D&X between the 16th and 20th weeks of pregnancy,[10] and he is able to perform 10 to 20 D&X abortions of the approximately 190 abortions per year he performs during this time period. *Id.*

Thus, the Nebraska ban potentially affects only between 1/19th and 2/19ths of his abortion practice – hardly a "large fraction" of women seeking abortion from him. The impact of the Nebraska statute could be even further minimized by delivery of the fetus that presents footling breech without the separate killing act that the statute requires for liability. That is, the woman's cervix might be mechanically or chemically dilated so that the fetal head does not lodge in the uterus or the fetal head might be reduced in size through cephalocentesis if the fetus has hydrocephalus. *See* this Brief at 13-15.[11]

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[10]After 20 weeks, Dr. Carhart usually induces fetal death prior to performance of any procedure. *Stenberg*, 11 F. Supp. 2d at 1121-22 (Supp. app. 59-60). Because the fetus is not living upon partial delivery, the Nebraska partial-birth ban would have no application in such cases.

[11]Since the Nebraska statute requires that a living fetus be killed, liability under the statute can also be avoided by initially cutting the umbilical cord of the fetus in a footling breech position, thereby causing the death of the fetus before partial vaginal delivery of the fetus, as Dr. Carhart (continued...)

Respondent's facial attack on the statute should thus not succeed under either the *Salerno* standard or *Casey*'s undue burden/large fraction rule. To strike the statute because there may be some particular circumstance in which D&X may have some health advantage over induction or D&E would turn the *Salerno* standard on its head. The *Salerno* standard provides that a law may not be held facially unconstitutional unless it there are no circumstances in which it has a valid application. The standard suggested by Respondent's claim against the Nebraska statute would hold it unconstitutional if there is any circumstance in which it has an invalid application.

If there is some circumstance in which the Nebraska statute may indeed be unconstitutional in its application – some situation in which the partially born fetus must be killed to avoid an appreciable health risk to the woman – then the proper remedy is for the Respondent to seek a declaration that the statute is unconstitutional *as applied to that circumstance*. Generalized claims concerning the supposed health advantages of the D&X procedure are not sufficient to strike the Nebraska statute in its entirely and in all its applications.

B. *The Absence of a Generalized Exception Permitting Partial-Birth Abortion for Maternal Health Does Not Unduly Burden the Right to Decide to Terminate Pregnancy.*

The claim that any asserted maternal health interest at stake in pregnancy termination always overrides any interest that the State might assert in the protection of fetal life lies at the heart of the Respondent's case. "A select panel convened by [the American Academy of Obstetrics and Gynecology] could

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[11](...continued)
states he does in most instances. J.A. 56-57.

identify no circumstances under which this [D&X] procedure . . . would be the only option to save the life or preserve the health of the woman." J.A. 600. Nevertheless, Respondent argues that any asserted maternal health advantage, no matter how conjectural or speculative, justifies performance of the D&X procedure in preference to alternative procedures as a matter of constitutional law.

The Nebraska statute contains no exception to its prohibition on partial-birth abortion for instances in which partial-birth abortion is claimed to be necessary for maternal health. This does not, however, contradict the holding of this Court that abortion must always be available for "pregnancies that endanger life or health." *Casey*, 505 U.S. at 846.

The Nebraska statute does not prohibit termination of any pregnancy that threatens maternal health. It forbids only the killing of a child in the birth canal with specific intent to do so. Moreover, it allows for the use of alternative pregnancy termination techniques, thereby assuring that abortion will always be available for pregnancies that endanger health.

The Respondent would stretch the *Casey* requirement for a "health" exception to a *ban* on abortion to encompass the principle that the "safest" *type* of abortion should always be accessible, basing his claim on older decisions of this Court which appeared to hold that maternal health must always trump any interest in fetal life in regulating the manner in which abortion is performed. *See Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 768-69 (1986); *Colautti v. Franklin*, 439 U.S. 379, 400 (1979); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 78-79 (1976).

But *Casey* reversed the Court's previous decisions in *Thornburgh*, *Colautti*, and *Franklin* insofar as they completely

discounted any interest in protection of pre-viable fetal life in favor of maternal health. As *Casey* held, the "basic flaw" in *Roe* and its progeny had been that they "undervalue[] the State's interest in the potential life within the woman." 505 U.S. at 875. The Court proceeded to hold that the State has a "substantial interest" in fetal life throughout pregnancy and that "[t]he very notion that the State has a substantial interest in potential life leads to the conclusion that not all regulations must be deemed unwarranted." *Id.* at 876. Thus, the State is permitted to enact measures "which favor childbirth over abortion, even if those measures do not further a [maternal] health interest." *Id.* at 886.

The informed consent/waiting period requirements upheld in *Casey* plainly involved sacrificing maternal health interests to the State's interest in the fetus. *See Casey*, 744 F. Supp. 1323, 1351 (E.D. Pa. 1990) (findings of fact). As the trial court in *Casey* found,

> The record . . . amply supports [a holding that the waiting period burdens the right to abortion]. However, I shall only briefly summarize my findings. Only a very small percentage of women are ambivalent concerning whether to have an abortion when they arrive at the facility. Once a woman gives her informed consent to the abortion procedure, there is absolutely no reason for delay. In fact, a mandatory 24-hour waiting period could, in reality, lead to delays in excess of 24 hours and perhaps as long as two weeks given the current practices of abortion providers and the individual circumstances of each patient. Any such delay presents an increased risk to the health of the patient. In some cases, the delay could force the woman into the second trimester of her pregnancy. This would increase the cost of the procedure, as well as the risk.
>
> Moreover, a mandatory 24-hour waiting period would require two visits to the abortion provider. This would

> double the woman's travel time, her exposure to the harassment of demonstrators located outside of most abortion facilities on a regular basis, and significantly increase her cost in obtaining the procedure. Further, women that work in the home and have children will have to expend additional sums for day care or baby sitting services, and women working outside the home will be required to take additional time off work. The economic impact of this provision will be most burdensome upon those women with the least financial resources, the poor and the young. Finally, women living in rural areas and those women that have difficulty explaining their whereabouts, such as school age women, battered women, and working women without sick leave, will also experience significant burdens in attempting to effectuate their abortion decision, if a mandatory 24-hour waiting period were in place.

Id. at 1379 (footnotes omitted). The Nebraska statute imposes no greater risks or burdens on maternal health interests for women seeking abortion than the significant risks and burdens imposed by the informed consent/waiting period requirements at issue in *Casey*.

The informed consent/waiting period requirements upheld by *Casey* applied even to abortions performed in early stages of pregnancy, while the Nebraska statute applies only to children in the process of birth when, as your Amici argue, the State has an enhanced interest in protecting the life of the child. If the waiting period/informed consent requirements that impose the sort of risks and burdens found by the district court in *Casey* ***may*** be sustained, then even greater risk and burdens may logically be permitted in furtherance of the State's interest in protecting children in the process of birth.

Similarly, this Court also upheld the medical emergency exception at issue in *Casey*, although it permits performance of an immediate abortion only to avert death "or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function." 505 U.S. at 880 (quoting Pa. Cons. Stat § 3203 (1990)). So long as "serious risk" includes any "significant threat" to the life or health of the woman, the medical emergency definition imposed no undue burden on the abortion liberty. *Casey*, 505 U.S. at 880. Again, maternal health interests were not deemed to defeat effectuation of contrary state interests in every case. Only if regulation represented some "significant" health threat to women choosing abortion would it be deemed unconstitutional.

In the present case, there is no convincing evidence that the woman must bear any health risk as the result of choosing available methods of abortion other than the D&X. But assuming arguendo there were some health advantage to D&X in some circumstance, there is no evidence that it is sufficiently significant to justify the conclusion that failure to include a generalized health exception in the Nebraska statute would represent an undue burden on a decision to terminate a pregnancy.

CONCLUSION

For the foregoing reasons, Amici Curiae request this Court to reverse the Eighth Circuit's decision and uphold Nebraska's partial-birth abortion ban.

Respectfully submitted,

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IN THE

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, GINA DUNNING, Director of Regulation and Licensure of the Nebraska Department of Health and Human Services, and CHARLES ANDREWS, M.D., Chief Medical Officer of the State of Nebraska,

Petitioners,

v.

LEROY H. CARHART, M.D.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF ON BEHALF OF NATIONAL ASSOCIATION OF PROLIFE NURSES, INC. IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

The National Association of Prolife Nurses, Inc. hereby requests, pursuant to Rules 21.2(b) and 37.3 of the Rules of this Court, leave to file the accompanying brief as *amicus curiae* in support of petitioners. *Amicus* has requested consent to file this brief from counsel for petitioners and respondent, but both parties have withheld consent.

The National Association of Prolife Nurses ("the Association") is a non-profit organization with several hundred members engaged in the profession of nursing. The members live and work in some 46 states of the United States of America. The members are united by a shared dedication to the ideals of their caring and ministering profession, the promotion of health, the alleviation of suffering, and the respect for and preservation of human life.

The Association strives to foster among its members, in the nursing profession in general, in the larger medical community, and in society at large an appreciation of the worth and dignity of human life. The Association shares the judgment of Congress, most state legislatures, and the vast majority of American citizens (as reflected in polling data) that, whatever differences of opinion may exist on the issue of abortion, the medical procedure(s) popularly identified as partial-birth abortion are beyond the pale of decency and should not be tolerated by a civilized and humane society.

When a medical procedure is allowed which shocks the conscience of a great many people, the damage is wide-ranging. Among those who suffer a distinct harm are the nurses who are called upon to participate in the procedure in

derogation of their moral, ethical, and professional values. These nurses' own right to self-definition of the principles by which they will live and act is compromised, along with their livelihoods and careers. And often it is the nurses who can provide witness to the gravest of abuses. For example, Brenda Pratt Shafer, R.N., in offering a first-hand account of the enormity of partial-birth abortion to the Senate Judiciary Committee, disclosed the stark and appalling brutality of the process. Hearing Before the Senate Judiciary Committee on H.R. 1833, Nov. 17, 1995, Hearing Transcript at 17-18.

Nurses should not be subjected to assisting the performance of partial-birth abortions. The health care profession should not be distracted, demeaned, and insensitized by tolerance or acceptance of partial-birth abortion. And the overwhelming judgment of the American people should not be disregarded and its democratic will flouted by judicial refusals to prohibit a practice that the people find intolerable.

Amicus believes that it offers, from the context of the nursing profession, a valuable perspective on this case which will assist the Court in evaluating Nebraska's action, through its legislative and executive branches, to establish strict limits on partial-birth abortion and the Eighth Circuit's invalidation of that state law.

Respectfully submitted,

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INTEREST OF *AMICUS CURIAE*

The National Association of Prolife Nurses, Inc. respectfully submits this brief as *amicus curiae* in support of petitioners[1]. The interest of *Amicus* is fully set forth in the Motion for Leave to File Brief as *Amicus Curiae*, printed herewith *ante*.

SUMMARY OF ARGUMENT

Amicus is concerned that proponents of an ethic profoundly disrespectful of human life are thwarting the will of the American people and the results of the democratic process by preventing laws which impose a non-absolute ban on partial-birth abortion from going into effect. The vast majority of our citizens and their lawmakers have concluded that partial-birth abortion simply goes too far and cannot be tolerated by a civilized and humane society. The practitioners of, and the advocates for, partial-birth abortion not only claim that it is medially indistinguishable from other abortion methods but suggest that it cannot be defined or described in any way that allows an adequately clear differentiation to be made. *Amicus* supports the drawing of medical and ethical distinctions to prevent further degradation in the respect accorded human life. It believes that partial-birth abortion, by its very nature, falls outside the scope of the abortion rights articulated by this Court, but that, even if it is simply "another method of abortion," the non-absolute prohibition worked by the Nebraska statute does not impose an undue burden on abortion rights.

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1. Counsel for *Amicus* is solely responsible for the authorship of this brief. No one other than *Amicus*, its members, and its counsel has made a monetary contribution to the preparation or submission of the brief.

ARGUMENT

I.

NEBRASKA'S PARTIAL-BIRTH ABORTION STATUTE DEFINES ITS SUBJECT MATTER WITH ADEQUATE SPECIFICITY AND CANNOT REASONABLY BE INTERPRETED AS APPLYING TO CONVENTIONAL ABORTION METHODS.

Nebraska, along with the majority of the 50 states, has enacted legislation to impose a fairly comprehensive ban on an especially shocking procedure for destroying human children when they are partly inside and partly outside their mothers' wombs. Neb. Rev. Stat. §§ 28-326(9) and 28-328(1)-(4) ("the Act" or "the Statute"). This procedure occupies a shadowy place in the nether world between abortion and infanticide and is most frequently referred to as "partial-birth abortion." In the arenas of politics and public debate, the participants — supporters and opponents alike — have appeared to possess quite a clear understanding of what partial-birth abortion is. With the commencement of litigation, however, what has been clear is suddenly claimed to be intolerably murky.

Indeed, the principal challenge mounted by respondent is to the alleged overbreadth and vagueness of the Statute, which respondent contends, and the lower courts have agreed, should be read as embracing not only the relatively rare procedure of partial-birth abortion (or, as it is denominated in medical literature, "intact dilation and evacuation" or, more frequently, "dilation and extraction" ["D&X"]), but also the most common method of second-trimester abortion, "dilation and evacuation" ("D&E"). *Carhart v. Stenberg*,

192 F.3d 1142, 1145 (8th Cir. 1999). *Amicus* finds it curious that statutory language painstakingly developed with input from an array of legal, political, and medical professionals (including both opponents and supporters of the broad availability of conventional abortions) could fall so short of the mark as to be overbroad and vague to the point of unconstitutionality. If the statutory language is, in fact, so hopelessly vague, partial-birth abortion may be unique among medical procedures (and, for that matter, among human acts in general) in being literally indescribable. This seems most unlikely. Unspeakable it may be, but scarcely indescribable.

A more plausible explanation suggests itself: the source of all this vagueness is not the text of the Act, but the dictates of legal strategy. Respondent's effort has been to expand through interpretation the scope of the Act so that it imposes restrictions on more commonly performed methods of abortion. The lower courts' apparent course was, not to read the Statute narrowly and in conformity with its intent and with constitutional limitations, but to import breadth and ambiguity into language that aims at being specific and precisely tailored. By so doing, respondent and the lower courts were able to point to the obvious unconstitutionality, under *Roe v. Wade*, 410 U.S. 113 (1973), and its progeny, of a law which they professed to view as banning not only the D&X but also the D&E procedure, and therefore imposing an undue burden on abortion rights.

Amicus leaves to the parties the details of the debate over statutory construction. *Amicus* notes, however, the inherent implausibility and unsustainability, of the common pattern of action in Nebraska and other states. Legislature after legislature has responded to the overwhelming wish of

their electorates to ban a medical procedure that offends the public's senses of decency and humanity; and judge after unelected judge has struck down these bans after finding that no draftsman seems capable of adequately describing the intolerable act. (This outcome is not invariable. One circuit court of appeals has found the text of states' partial-birth abortion statutes to be both comprehensible and constitutional. *Hope Clinic v. Ryan*, 195 F.3d 857 [7th Cir. 1999].) *Amicus* hopes that this Court will impart sufficient clarity to the subject of drafting restrictions on partial-birth abortion to enable the democratic will of the people of the United States to be fulfilled.

II.

THIS COURT HAS NEVER ARTICULATED A CONSTITUTIONAL RIGHT TO TERMINATE THE LIFE OF A HUMAN CHILD OUTSIDE THE WOMB.

In ordinary thought and speech, a mother's womb has long been considered the place of ultimate peace and safety, from which a child emerges to begin to face the travails of the outside world. In current American constitutional law, ironically, the womb is a place of unparalleled danger. Inside, an unborn child is at the mercy of its mother's constitutional right to abort (a right first discovered in 1973); once safely outside, however, the child may face many perils, but no one is at liberty to kill it, deliberately, directly, and with impunity. Partial-birth abortion presents a situation where a child is neither wholly inside nor wholly outside the womb. The doctor performing the procedure has partially delivered the living baby, but has left the head inside the womb, and then proceeds to make an opening into the cranial cavity, suction out the baby's brains, and often crush its skull, prior

to removing the head from the womb. Statement of Brenda Pratt Shafer, R.N., at Hearing Before the Senate Judiciary Committee on H.R. 1833, Nov. 17, 1995, Hearing Transcript at 17-18.

Whatever the medical purpose, if any, of the partial-birth abortion procedure,[2] its legal purpose would seem to be to offer a basis for characterizing the procedure as an act of "abortion" (since a portion of the baby has not emerged from the womb before the baby's death) rather than an act of infanticide. The practitioners and defenders of partial-birth abortion therefore claim that the procedure is entitled to the constitutional protections accorded the broad category of acts constituting "abortion," as those protections were first enunciated in *Roe v. Wade* and refined and developed in the progeny of *Roe*.

This argument, however, does not survive a careful reading of *Roe v. Wade* and the succeeding cases of this Court. The Texas statutes at issue in *Roe* (and the conduct they dealt with) concerned the termination of fetal life while the fetus was still in its mother's womb. The Court's opinion in *Roe* expressly noted that *another* Texas statute, Article 1195 of Chapter 9 of Title 15 of the Texas Penal Code, was *not* being challenged. 410 U.S. at 117 n.1. Article 1195 imposed (and still imposes, for it has never been invalidated or repealed) criminal penalties on anyone who "shall during parturition of the mother destroy the vitality or life in a child *in a state of being born and before actual birth*, which child

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2. It is questionable, at best, that there is any legitimate medical reason to use partial-birth abortion rather than some other abortion method. Even the American Medical Association, which supports the broad availability of abortion in general, has taken the position that use of partial-birth abortion is never medically indicated.

would otherwise have been born alive. . . ." *Id.* (emphasis added) Clearly Article 1195 covers that very middle ground — when a baby is "in a state of being born" but "before actual birth" — which partial-birth abortion attempts to occupy and exploit. However, just as *Roe v. Wade*, in enunciating the general constitutional right to abortion, did nothing to impair the operation of Article 1195, so no subsequent decision of this Court has done what *Roe* did not do.[3]

Consequently, respondent and the courts below are mistaken in applying the analysis and protections of *Roe v. Wade* and its progeny outside the scope of the conduct at issue in those cases — termination of fetal life within the womb. The Eighth Circuit is attempting at respondent's urging, a significant expansion of the Supreme Court's abortion jurisprudence so as to remove from the judgment of the states the authority to adopt reasonable legislation governing partial-birth abortion.

3. Article 1195 is still valid Texas law. It is now found at Tex. Rev. Civ. Stat. art. 4512.5. Not long after *Roe v. Wade*, the Attorney General of Texas rendered a formal opinion, explaining that Article 1195 was able to survive *Roe* because it was not, strictly speaking, an *abortion* statute. Texas Att'y Gen. Op. H-369 (Aug. 13, 1974). Indeed, partial-birth abortion has been recognized (even by strong supporters of abortion of rights) to be a form of infanticide rather than a form of abortion.

III.

EVEN IF PARTIAL-BIRTH ABORTION IS DETERMINED TO FALL WITHIN THE SCOPE OF "ABORTION" AS IT IS GOVERNED BY THE HOLDINGS IN *ROE v. WADE* AND ITS PROGENY, THE NEBRASKA STATUTE DOES NOT RUN COUNTER TO THOSE HOLDINGS OR INFRINGE UPON THE RIGHT TO ABORTION ARTICULATED BY THIS COURT.

Assuming, for the sake of argument, that (despite footnote 1 of *Roe v. Wade*) *Roe* and its progeny are held to govern partial-birth abortions, *Amicus* asserts that there is nothing in that case law warranting the invalidation of the Act. The Act does not prevent, or even interfere in any substantial way with, the exercise of the abortion rights recognized by this court. The essence of those rights is a pregnant woman's ability to choose *whether or not* to terminate her pregnancy. The rights do not go deeper to give her a constitutional right to terminate her pregnancy *in any way she may choose*, or in any way her physician may choose.

This Court's abortion jurisprudence clearly expresses this limitation. In *Maher v. Roe*, 432 U.S. 464 (1977), for example, the Court stated:

> Roe did not declare an unqualified "constitutional right to an abortion," as the District Court seemed to think. Rather, the right protects the woman from unduly burdensome interference with her freedom to decide *whether* to terminate her pregnancy.

432 U.S. at 473-74 (emphasis added). In *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), the plurality opinion rejected the "trimester framework" announced in *Roe v. Wade*, because its application

> . . . has led to the striking down of some abortion regulations which in no real sense deprived women *of the ultimate decision*. . . . "the decision *whether* to bear or beget a child." (citation omitted)

505 U.S. at 875 (emphasis added).

In *Casey*, the plurality opinion favored replacing the "trimester framework" of *Roe* with a pre-viability and post-viability framework. Under the latter framework, "a State may not prohibit any woman from making *the ultimate decision to terminate her pregnancy* before viability." 505 U.S. at 879 (emphasis added) (reaffirming the Court's holding in *Roe*). After viability, a state may go so far as to "proscribe" abortion altogether "except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." 505 U.S. at 879 (quoting verbatim from the Court's holding in *Roe*, 410 U.S. at 164-65).

Since neither of the foregoing standards is violated by the Statute, the fact that the Statute draws no distinction between the application of the partial-birth abortion method to unborn children before and after viability is of no moment. The Statute imposes nothing more than a non-absolute ban on one specific method of abortion. It does not prohibit a woman from making her "ultimate decision." And since it does not proscribe (or even apply to) abortion generally, there

is no requirement under *Roe* or *Casey* for either a life or a health exception.[4]

The state regulations of abortion considered by this Court in *Casey* and other cases — including such provisions as waiting periods, informed consent, parental consent, and spousal notice — typically are burdens on abortion generally. The Act does not impose any burden on a woman's ability to decide whether or not to have an abortion. According to the plurality opinion in *Casey*, it is only when a state regulation interferes with a woman's ability to make *that* decision that the state "reach[es] into the heart of the liberty protected by the Due Process Clause." 505 U.S. at 874. Finally, even interference with that decision must be *undue* interference before it can be held to be unconstitutional. The non-absolute prohibition of a single method of abortion (a method which is especially grisly and painful, which is never medically indicated, and which there are many legitimate state interests for banning) can scarcely be considered "undue."

Even so venerable a constitutional right as the First Amendment right of free speech — a right which is expressly set forth in the text of the Bill of Rights and which has been recognized for over 200 years — has been held to be capable of limitation by reasonable time, place, and manner restrictions. *Kovacs v. Cooper*, 336 U.S. 77 (1949). Is there any reason why the right to abortion — a right which is not expressly mentioned anywhere in the Constitution and which

---

4. The Act does, of course, contain an exception for the life of the mother. In that respect, the Nebraska Legislature did not even go as far in limiting partial-birth abortion as it constitutionally could have gone under *Roe* and *Casey*.

has a pedigree of a mere 27 years — should be deemed exempt from similar reasonable restrictions? If there are legitimate and substantial reasons for the state to impose a limitation which does no more than reasonably channel the right's exercise, why should such a limitation not be allowed? And since a reasonable limitation of time, place, and manner in which the right to abortion can be exercised is, by definition, not a proscription of abortion, there is neither binding authority nor even a logical reason to require "life or health of the mother" exceptions to such a limitation.

It must be remembered that the "life and health of the mother" exceptions required under *Roe* are exceptions *to the absolute proscription of abortion*, not to its reasonable regulation. 410 U.S. at 164-65. Consider two simple examples, one actual and one hypothetical. First, all states have seen fit to categorize the performance of abortions as falling within the practice of medicine and limiting such performance to licensed physicians. Undoubtedly this regulation may impose *some* burden on a woman's ability to procure an abortion, if only because there is a limited supply of doctors and doctors may charge substantial fees for their services. But this burden — prohibiting the performance of abortions by those not licensed to practice medicine — although it obviously exists both before and after viability, has been held permissible by this Court without any "life or health of the mother" exceptions. *Mazurek v. Armstrong*, 520 U.S. 968 (1977).

Second, suppose that a chemist devised a new substance — call it "Compound X" — which is a powerful and unstable explosive but also happens to be (as a feature of its non-explosive chemical properties) an extraordinarily sure and effective abortifacient. Can there be any doubt that a state

could constitutionally ban or restrict the possession and use of Compound X, including the absolute prohibition of its use as a method of abortion, without allowing any exceptions for the life or health of a pregnant woman who wishes her physician to use Compound X? Such regulation would not proscribe *abortion*, but only a particular method of abortion which the state would have legitimate and substantial reasons for proscribing.

In justification of the partial-birth abortion statute at issue in *Planned Parenthood v. Verniero*, 41 F. Supp. 2d 478 (D.N.J. 1998), the New Jersey Legislature identified nine separate interests which it defended as legitimate and compelling governmental interests.[5] Any of them standing alone could serve as an adequate reason for enacting New Jersey's non-absolute ban on partial-birth abortion, a statute comparable to Nebraska's partial-birth abortion statute. Consider just one of those interests — the state's interest in protecting a fetus from the intentional infliction of undue and unnecessary pain. This is an interest in preventing inhumane conduct which would easily justify the prohibition of cruel acts against even domestic animals, to say nothing of unborn babies.

In the case of unborn babies, of course, the State has the far more weighty interest of protecting human life. This interest is not nullified by adversion to *Roe*'s agnosticism about when human life begins. *Roe* did nothing more than

---

5. New Jersey was denied the opportunity to prove the compelling nature of those interests by the district court's refusal to allow expert testimony to prove material facts concerning those interests. In the case at bar, the opinions below do not include any analysis of the governmental interests furthered by the Nebraska partial-birth abortion statute.

state that this Court, in 1973, "at this point in the development of man's knowledge," could not supply the answer. 410 U.S. at 159. But the Court also acknowledged, in the companion case to *Roe*, that a State engaged in lawmaking possesses "the right to readjust its views and emphases in the light of the advanced knowledge and techniques of the day." *Doe v. Bolton*, 410 U.S. 179, 191 (1973).

No one can deny that scientific knowledge about fetal development has increased vastly since 1973. Nebraska has done nothing more than act on the basis of that new knowledge to prevent an exceptionally brutal assault on an unborn child in those vulnerable moments when it is partly inside and partly outside the womb.

It must be acknowledged that the Act does nothing more than ban one particular method of killing an unborn child. The child that isn't destroyed by partial-birth abortion can still legally be killed in other ways that are no less direct and effective, if not quite so blatantly horrific. But the State of Nebraska has acted to prevent a procedure that, in addition to being of no demonstrated medical value, is barbaric to the point of shocking indecency.

In so doing, the State has not attempted to infringe upon the constitutional rights established in *Roe* and *Casey*. It has merely acted in conformity with those cases' acknowledgment that, as pregnancies proceed, the State's legitimate interests in those unborn children grow greater, and also in conformity with the advances in medical knowledge since *Roe*, which march inexorably in the direction of demonstrating from how very early a stage in a human pregnancy a fetus is undeniably a living human being.

Nebraska has determined that a procedure in which a doctor partially delivers, and then proceeds to destroy, a human baby creates a constitutional context in which it can legitimately act. It has done so with considerable moderation: it has expressly exempted the women receiving partial birth abortion from criminal sanction; and it has recognized a "life of the mother" exception, so that if there ever is a case (unlikely though that may be) in which partial-birth abortion is needed to save a mother's life, resort to it can lawfully be made. It has chosen not to recognize a "health of the mother" exception, presumably because it perceives that, in the case of an almost-born baby, an actual life rather than a potential life is at issue and only the value of one life could conceivably outweigh the value of another life.

Amicus perceives nothing in any prior ruling of this Court which requires that the Statute be struck down. Beyond that, *Amicus* believes that nothing in the Statute violates any provision of the United States Constitution, which is profoundly respectful of both the legislative prerogatives of states and the protected status of innocent human life. U.S. Const. amend. X; U.S. Const. amend. XIV; *Levy v. Louisiana*, 391 U.S. 68 (1968). *Amicus* urges the Court to use the opportunity presented by this case to declare that the people and their lawmakers are not powerless to limit even the grossest assaults on innocent human life.

CONCLUSION

For the foregoing reasons, *Amicus* respectfully requests this Court to reverse the decision of the United States Court of Appeals for the Eighth Circuit and to vacate the injunction on the enforcement of Nebraska's partial-birth abortion statute.

Respectfully submitted,

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In The

Supreme Court of the United States

DONALD STENBERG, in his official capacity as Attorney General for the State of Nebraska, *et al.*,

Petitioners,

vs.

LEROY H. CARHART,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

MOTION FOR LEAVE TO FILE AMICUS CURIAE BRIEF AND BRIEF AMICUS CURIAE OF RIGHT TO LIFE ADVOCATES, INC. IN SUPPORT OF THE PETITIONERS

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MOTION FOR LEAVE TO FILE AMICUS CURIAE BRIEF

Comes now RIGHT TO LIFE ADVOCATES, INC. ("Life Advocates"), by and through its attorney of record, and, acting pursuant to Rule 37 of the Rules of this Court, moves the Court for leave to file an amicus curiae brief in the within cause on behalf of Petitioners, showing respectfully the following:

1. By Letter dated February 18, 2000, Deputy Attorney General Steve Grasz of the State of Nebraska advised the attorney herein that "[p]ursuant to our agreement with opposing counsel regarding mutual consent to a limited number of amicus briefs, we are not able to provide consent to your brief."

2. Life Advocates is a non-profit membership corporation organized under the laws of the State of Texas with a tax exempt status under §501(c)(4) of the Internal Revenue Code of the United States. It is a Houston-based pro-life organization dedicated to the preservation of the sanctity of human life from conception until natural death.

The instant case presents an issue of first impression for this Court and, in addressing same, it is believed that the Court will have an opportunity to reconsider and overrule *Roe v. Wade*, 410 U.S. 113 (1973). Life Advocates is interested in having states like Nebraska enact and enforce laws proscribing partial birth abortions because this will prevent some abortions and, as a result, save some human lives. It also has an abiding and obvious interest in the overrule of *Roe*.

3. Based on the approach to this case taken by the Court of Appeals and this Court's Order granting review herein, it is believed that an extremely important issue – the inapplicability of *Roe* and the "undue burden" standard of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 883 (1992), to Nebraska's proscription of partial birth abortions – either will not be addressed or addressed fully by the parties to this case.

In this regard, the Texas anti-abortion law held unconstitutional in *Roe* dealt only with abortion *in utero*. This Court has never addressed any right of abortion where an Unborn Child is delivered at least partially *ex utero* or where parturition of the mother has commenced. That being the case, questions of the creation of a new right to abortion or the extension of *Roe* into this area should come to the fore, giving the Court an opportunity to reconsider and overrule *Roe* on constitutional and jurisdictional grounds and, in the process, to hold that an Unborn Child is a person under the 14th Amendment to the Constitution.

4. It is believed that the Amicus Curiae Brief of Life Advocates, which follows this Motion, will be of assistance to the Court in deciding this case and in correcting the abuse of power evident in *Roe*.

Respectfully submitted,

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INTEREST OF THE AMICUS CURIAE

Right to Life Advocates, Inc. is a Texas non-profit membership corporation with a tax-exempt status under Section 501(c)(4) of the Internal Revenue Code of the United States. It is a Houston-based pro-life organization dedicated to the preservation of the sanctity of human life from conception to natural death. It is opposed to the practice of abortion as provided by the companion cases of *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973), and their progeny.

The instant case presents the Court with an opportunity to determine an issue of first impression, i.e., whether the State of Nebraska (and other States) may enact legislation which proscribes the deliberate and intentional partial delivery of an Unborn Child into the mother's vagina for the purpose of performing an abortion procedure which the performer knows will kill and does kill such Unborn Child. Texas has a somewhat similar law which may be affected by the Court's decision in this case. Amicus is interested in the enactment and enforcement of laws of this nature because this will prevent some abortions and, as a result, save some human lives.

Moreover, this case presents the Court with the opportunity to reconsider and overrule *Roe v. Wade*. Amicus has an abiding and obvious interest in such overrule and in the constitutional protection of the fundamental natural right to life of Unborn Children in this Nation.

SUMMARY OF ARGUMENT

A. The Court of Appeals erred when it held unconstitutional Nebraska's statutory ban on partial birth abortions based on the "undue burden" test of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 883 (1992), because the abortion "right" established in *Roe v. Wade* did not apply to such abortions. This is because *Roe* dealt only with Texas' proscription of abortion *in utero*. The Nebraska law addresses abortion where the Unborn Child, or a substantial part thereof, is deliberately and intentionally delivered into the mother's vagina for purposes of destroying the life of such Unborn Child and results in such destruction.

Moreover, this Court has never extended the abortion "right" of *Roe* to cover abortion where part of the Unborn Child is delivered vaginally or where childbirth has commenced.

B. This Court should not create a new right for partial birth abortions because the Constitution recognizes no such right, nor would it meet the traditional constitutional tests for recognition of an unenumerated fundamental right set by this Court. See *Bowers v. Hardwick*, 478 U.S. 186, 191-192 (1986).

Further, creation of any such new right would deprive Unborn Children of their lives and property interests without due process of law, in violation of the Due Process Clause of the 5th Amendment to the Constitution. Unborn Children are persons within the reach of such Clause since they meet the live human being test of personhood under the Equal Protection Clause of the 14th Amendment to the Constitution. See *Levy v. Louisiana*, 391

U.S. 68, 70 (1968). Personhood under such Clause constitutes personhood under the Due Process Clause of the 14th Amendment and should constitute personhood under the Due Process Clause of the 5th Amendment.

In addition, the Court would lack personal jurisdiction over the affected Unborn since they were not represented in the instant case. See *McArthur v. Scott*, 113 U.S. 340, 391-392, 395, 404 (1885). Hence, creation of such a right would be unconstitutional as violative of the Due Process Clause of the 5th Amendment.

Finally, creation of any such right, which would be in tanden with *Roe*, would compound and vest further the constitutional errors of *Roe*.

C. The abortion "right" of *Roe* should not be extended to cover partial birth abortions because *Roe* is an unconstitutional decision and should be overruled instead of expanded or enhanced.

1. The Due Process Clause of the 14th Amendment does not include any liberty of abortion. The Constitution is silent on this subject, and domestic law had long considered induced abortion to be a crime. See *Casey, supra*, 505 U.S. at 980 (Scalia, J., joined by Rehnquist, C.J., White, J. and Thomas, J., concurring in the Judgment in part and dissenting in part). Moreover, such "right" did not meet any standard established by this Court for the recognition of an unenumerated fundamental right.

2. *Roe*, is void as violative of the Due Process Clause of the Fifth Amendment and of fundamental principles of personal jurisdiction. Neither Abortion "Survivor" Children nor Unborn Children were represented before the

3-Judge District Court or this Court in *Roe* as they were entitled, and neither Court had personal jurisdiction over such Children. The abortion "right" of *Roe* discriminates invidiously against affected Unborn Children as compared to corporations and the nonabortion born. *Roe* permitted the lives and property interests of Abortion "Survivor" Children and affected Unborn Children to be destroyed.

3. Finally, the Court in *Roe* exceeded its jurisdiction under Article III, §2, of the Constitution with its manufacture of the abortion "right" and its deprivation and limitation of reserved constitutional authority of the states to legislate, etc. in this area of interest.

Roe should be reconsidered and overruled and, in the process, the Court should hold that an Unborn Child is a person covered by the Due Process Clause of the 14th Amendment.

ARGUMENT

I.

THE COURT OF APPEALS ERRED IN APPLYING THIS COURT'S UNDUE BURDEN STANDARD OF *CASEY* TO THE NEBRASKA STATUTORY LAW INVOLVED

A. The Nebraska Statutory Law. §28-328, *Rev. Stats. of Neb.* (1998 Cum. Supp.), provides, in pertinent part:

> (1) No *partial-birth abortion* shall be performed in this state, unless such procedure is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.
>
> (2) The intentional and knowing performance of an unlawful partial-birth abortion in violation of subsection (1) of this section is a Class III felony.
>
> (3) No woman upon whom an unlawful partial-birth abortion is performed shall be prosecuted under this section or for conspiracy to violate this section.
>
> (4) The intentional and knowing performance of an unlawful partial-birth abortion shall result in the automatic suspension and revocation of an attending physician's license to practice medicine in Nebraska by the Director of Regulation and Licensure pursuant to sections 71-147 to 71-161.20. (Emphasis added.)

* * *

§28-326(9), *Rev. Stats. of Neb.* (1998 Cum. Supp.), defines "partial-birth abortion" as

> an abortion procedure in which the person performing the abortion *partially delivers vaginally* a living unborn child before killing the unborn child and competing the delivery. For purposes of this subdivision, the term *partially delivers vaginally* a living unborn child before killing the unborn child *means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.* (Emphasis added.)

B. Inapplicability of *Roe v. Wade*, Etc. to This Case. In *Roe v. Wade, supra,* 410 U.S. 113, this Court said that "[t]he Texas statutes that *concern us here* are Arts. 1191-1194 and 1196 of the State's Penal Code" (*id.* at 117), and quoted them in the first five paragraphs of footnote 1 (*id.* at 117-118, n. 1). These statutes were the ones "under attack here" (*id.* at 116). Article 1191 of the former *Texas Penal Code* proscribed procurement of an abortion upon a pregnant woman, and defined abortion as meaning " 'the life of the fetus or embroy shall be destroyed *in the woman's womb, or that a premature birth thereof be caused*' " (*id.* at 117, n. 1). (Emphasis added.) Under Article 1196 of such former Code, the Chapter was not to apply to " 'an abortion procured or attempted by medical advice for the purpose of saving the life of the mother' " (*id.* at 118, n. 1).

The Court was not concerned with Article 1195 of such Code which was not challenged in the case. After quoting Articles 1191-1194 and 1196, above, it said, in pertinent part (*ibid.*):

> The foregoing Articles, together with Article 1195, compose Chapter 9 of Title 15 of the Penal Code. Article 1195, *not attacked here,* reads:
>
> "Art. 1195. Destroying unborn child
>
> "Whoever shall *during parturition of the mother* destroy the vitality or life in a child *in the state of being born and before actual birth, which child would otherwise have been born alive,* shall be confined in the penitentiary for life or for not less than five years." (Emphasis added.)[1]

[1] See *Vernon's Tex. Civ. Stats. Ann.,* Art. 4512.5.

Against this background, it is clear that the challenge before the Court in *Roe* involved the proscription of abortion *in utero,* that is, while the Unborn Child was " 'in the woman's womb' ", per the definition of abortion in Article 1191, above. it did not involve the proscription of abortion *ex utero,* that is, during childbirth per Article 1195 or where the Unborn Child was, to any extent, outside of the womb.

Moreover, this Court has never extended *Roe* or the abortion "right" established therein to situations where an Unborn Child is delivered partially into the vagina for purposes of destruction. Nor has it done so after the birth process has commenced.

Accordingly, *Roe* and its progeny, including *Planned Parenthood of Southeastern Pennsylvania v. Casey, supra,* 505 U.S. 883, are inapplicable to the fact situation presented by the Nebraska statutory law at bar.

C. The Court of appeals Erred in Applying *Casey* to the Nebraska Statutory Law at Issue. The Court of Appeals erred when it held unconstitutional Nebraska's statutory ban on partial birth abortions based on the "undue burden" standard of *Casey* because the abortion "right" established in *Roe* did not apply to such abortions.[2]

[2] In *Hope Clinic v. Ryan,* 195 F. 3d 857 (7th Cir. 1999), the Court of Appeals applied *Casey,* etc. and the abortion "right" of *Roe* to the partial birth abortion statutory bans of three other States. This approach was erroneous since the abortion "right" of *Roe* did not extend to partial birth abortions.

As shown above, *Roe* was concerned *only* with abortion *in utero*. It was never extended to cover the situation where the Unborn Child was partially *ex utero* or in the state of being born. Since §§28-326(9) and 28-328(1), above, proscribe partial birth abortions where the Unborn Child is delivered fully or in substantial part into the mother's vagina, etc., neither *Roe* nor *Casey* have any application to the constitutional merits of such legislation.

That being the case, the holding by the Court of Appeals that they would prohibit "the most common procedure for second-trimester abortions [the D&E procedure]" and, in so doing, "impose an undue burden on a woman's right to choose to have an abortion" (192 F. 3d at 1151) is erroneous.

Moreover, the Court took, as a given, that an abortion method, however named, where a portion of the Unborn Child is delivered outside of the uterus, was authorized under *Roe*. This position is erroneous since nothing in *Roe* supports or even addresses that subject.

Respondent acknowledged that, in a "D&E" (dilation and evacuation) procedure, dismemberment occurs after part of the fetus has been pulled through the cervix, and testified that he did not know of any way that dismemberment could occur inside the uterus since " '[i]t takes something that restricts the motion of the fetus against what you're doing before you're going to get dismemberment' " (192 F. 3d at 1147).[3] Such a D&E procedure is no

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[3] A second trimester D&E abortion at 14-20 weeks of pregnancy is a two stage procedure – dilating the cervix, followed a day later by vacuuming and scraping *within* the uterus. Mildred S. Hanson, M.D., "The Second Trimester D&E Abortion Procedure", pp. 1, 2, Mildred Hanson MD, Minneapolis, Minnesota – Abortion Clinics Online, hhtp://gynpages.com/hanson/2.html.

more or less than a partial birth abortion of a kind not covered by *Roe* and *Casey* and about which Nebraska (and the other States) may proscribe. The fact that he may have been performing such procedures with impunity and for some time could not fortify implicitly that it was authorized by *Roe* or provide insulation to him (or others similarly situated) from the proscriptions of such law. It means simply that Nebraska has moved to proscribe a practice deemed inimical to the public health, safety and morals in the State.

Accordingly, §§28-328(1) and 28-326(9) here involved do not constitute an undue burden to exercise of the abortion "right" created by *Roe*. Instead, they constitute reasonable and proper exercises of the State's reserved police power of protecting from destruction the lives of Unborn Children within the State. They bear a meaningful relation to a public end, namely, protection and enhancement of public safety and public morals, and the means employed are adapted reasonably to do this and are neither arbitrary nor oppressive. See *Treigle v. Acme Homestead Ass'n.*, 297 U.S. 189, 197 (1936). That the State of Nebraska has a legitimate interest in exercising legislative authority in the protection of unborn human life is unquestioned. See *Casey, supra*, 505 U.S. at 846.

II.

THIS COURT SHOULD NOT CREATE A NEW RIGHT FOR PARTIAL BIRTH ABORTIONS

Since the abortion "right" of *Roe* does not extend to a "right" to destroy an Unborn Child which is delivered partially into the mother's vagina, this Court, for a number of reasons, should not use this case to fashion a right to do so.

A. No Constitutional Right of Abortion Extending Ex Utero. There is *nothing* in the U.S. Constitution which would authorize the Court to fashion a new right for partial birth abortions. Not only is the Constitution silent on the subject of abortion, see *Casey, supra*, 505 U.S. at 980 (Scalia, J., joined by Rehnquist, C.J., White, J. and Thomas, J., concurring in the judgment in part and dissenting in part), but creation of such a right would not meet the traditional constitutional tests for recognition of an unenumerated fundamental right. See *Bowers v. Hardwick, supra*, 478 U.S. at 191-192. See Section III-A-1, pp. 13-14, below. Hence, creation of such a right would exceed the Court's jurisdiction under Article III, §2, of the Constitution.

If the Court were to create such a right, what would be its bounds? At what point in the delivery process would it commence and when would it terminate? Would it exist after delivery but before severance of the umbilical cord? Would it exist after parturition has commenced naturally? Or when it has commenced after inducement?

B. Absence of Personal Jurisdiction Over Affected Unborn Children. Unborn Children affected by partial birth abortions were not represented in the proceedings

in this case by guardian or next friend. Yet their vital interests were at stake. Since they were not represented before the lower courts herein, as they were entitled to be, see *McArthur v. Scott, supra*, 113 U.S. at 391-392, 395, 404, this Court lacks personal jurisdiction over them for any fashioning of a right in their mothers to destroy them by partial birth abortions. Any such action would be void as violative of the Due Process Clause of the 5th Amendment to the Constitution. See *ibid.*

C. Deprivation of the Lives and Property Interests of Affected Unborn Children Without Due Process of Law. Creation of any such new right would deprive affected Unborn Children of their lives and property interests without due process of law, in violation of the Due Process Clause of the 5th Amendment to thee Constitution. Unborn Children are persons[4] within the reach of such Clause since they meet the live human being test of personhood under the Equal Protection Clause of the 14th Amendment to the Constitution. See *Levy v. Louisiana, supra*, 391 U.S. at 70, where this Court declared, as to illegitimate children there involved, "[t]hey are *humans, live, and have their being*. They are clearly 'persons' within

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[4] In addressing the "personal security" aspect of a natural person, William Blackstone said that "THE right of personal security consists in a *person's* legal and uninterrupted enjoyment of *his life*, his limbs, his body, his health, and his reputation", and that "LIFE is the immediate gift of God, a right inherent by nature in every individual; and it begins in contemplation of law as soon as *an infant is able to stir in the mother's womb* * * *." I Blackstone, *Commentaries on the Laws of England* (circa 1765), pp. 123, 129.

the meaning of the Equal Protection Clause of the Fourteenth Amendment." (Emphasis added.) There is no distinction between persons under that Clause and the Due Process Clause of such Amendment. Well over a century ago, this Court declared that these clauses were *"universal in their application, to all persons within the territorial jurisdiction,* without regard to any differences of race, of color, or of nationality * * * ". *Yick Wo v. Hopkins,* 118 U.S. 356, 369 (1886). (Emphasis added.)

As shown below, Unborn Children have substantial legal recognitions and property interests under domestic U.S. law. The continuation of the lives of affected Unborn Children together with all of their property interests would be subject to destruction by any new right which this Court might create for partial birth abortions.

Amicus submits that the live human being test of *Levy* should also be the test of personhood of natural persons[5] under the Due Process Clause of the 5th Amendment. The operative wording of the two due process clauses is identical and their reaches are broad. Accordingly, this Court would lack constitutional jurisdiction to fashion a right to obtain a partial birth abortion since any such action would deprive affected Unborn Children of their lives and property interests without due process of law, in violation of such 5th Amendment.

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[5] *Roe*'s conclusion that "the unborn have never been recognized in the law as persons in the whole sense" (410 U.S. at 162) ignores the live human being test of personhood under the Equal Protection Clause of the 14th Amendment per *Levy,* above.

D. Further Vesting of Constitutional Error. As shown below, *Roe* is an unconstitutional decision, and any creation of a right for partial birth abortions, which would be in tandem with *Roe,* would compound and vest further the errors of *Roe.* Amicus submits that this Court should correct constitutional error when presented with the opportunity so to do, and that vested error should have no place in the constitutional law or life of this Nation.

III.

THE ABORTION "RIGHT" ESTABLISHED IN *ROE* SHOULD NOT BE EXTENDED TO COVER PARTIAL BIRTH ABORTIONS

A. Roe Is an Unconstitutional Decision. The abortion "right" of *Roe* should not be extended to cover partial birth abortions because *Roe* is an unconstitutional decision which should be overruled instead of expanded or enhanced.

1. The 14th Amendment to the Constitution Does Not Include Any "Liberty" of Abortion. While this Court fashioned the abortion right from the "liberty" reach of the Due Process Clause of the 14th Amendment, it is clear that the Constitution is silent on the subject of abortion. See *Casey, supra,* 505 U.S. at 980 (Scalia, J., joined by Rehnquist, C.J., White, J., and Thomas, J., concurring in the Judgment in part and dissenting in part). It does protect the life right of persons from federal and state deprivation without due process of law. It is inconceivable how the life right of persons so protected against state deprivations could be subordinated to a "liberty" to

destroy it prenatally by abortion when, as a matter of common knowledge, the lives of such persons commence prenatally.

Moreover, "the longstanding traditions of American society have permitted it [abortion] to be legally proscribed." *Ibid.* (Footnote omitted.) In *Roe*, this Court created a fundamental constitutional right of abortion. Fundamental liberties not enumerated in the text of the Constitution, however, have been defined as "those that are 'deeply rooted in the Nation's history or tradition' " or, more narrowly, "those interests that are 'implicit in the concept of ordered liberty' such that 'neither liberty nor justice would exist if [they] were sacrificed.' " *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 790-791 (1986) (White, J., joined by Rehnquist, J., dissenting). See *Bowers v. Hardwick, supra*, 478 U.S. at 191-192. Was abortion deeply rooted in the history or traditions of this Nation? Would liberty or justice cease to exist if the decision to abort was sacrificed? How could an act long recognized as criminal and evil achieve such a lofty stature?

In short, the Court exceeded its jurisdiction under Article III, §2, of the Constitution and in the process, deprived and limited the constitutional jurisdiction of the States in this area of vital interest.

2. *Roe* Is Void as Violative of the U.S. Constitution and Fundamental Principles of Personal Jurisdiction. At the threshold, it is well established that if a court in the United States violates the U.S. Constitution in a proceeding before it, it loses jurisdiction to proceed to judgment and any "judgment" which it might render would be

void. *Johnson v. Zerbst*, 304 U.S. 458, 467-468 (1938); *Windsor v. McVeigh*, 93 U.S. 274, 277-284 (1876). This Court is capable of violating the Constitution and even *admitted* that it and lower courts had done so with application of the doctrine of *Swift v. Tyson*, 16 Pet. 1 (1842). *Erie R. Co. v. Tompkins*, 304 U.S. 64, 77-78, 79-80 (1938). The unconstitutionality of *Roe* is pervasive:

a. No Representation of Abortion "Survivor" Children or Unborn Children. Neither Unborn Children nor Abortion "Survivor" Children were represented before the 3-Judge District Court or this Court in *Roe*. Abortion "Survivor" Children, i.e., Children who are brought forth alive *after* the abortion procedure but are doomed to die and do die primarily due to prematurity, abortional injury or lack of care are U.S. Citizens (with extremely minor exceptions) under the Citizenship Clause of the 14th Amendment and "persons" under the Due Process Clause of the 5th Amendment to the Constitution. Occasionally an Abortion "Survivor" Child is murdered outright. See *Showery v. State*, 690 S.W. 2d 689, 694, 695-696 (Tex. App. – El Paso 1985, pet. ref.) (where a physician drowned a girl of about 6-months gestational age in a bucket of water). *Roe* permitted such Children to be brought forth in an environment where the goal is death. These Citizen Children were entitled to be represented in the very proceedings which affected them so personally. Since they were not, *Roe* is void as violative of the Due Process Clause of the 5th Amendment. See, in different context, *Pennoyer v. Neff*, 95 U.S. 714, 733, 734 (O.T., 1877).

Unborn Children also were entitled to be represented in *Roe* since they met the live human being test of 14th Amendment personhood per *Levy v. Louisiana*, above.

Since born persons have 14th Amendment personhood, and since such persons did not originate at birth, it follows that their personhood existed prenatally. This is fortified by the fact that Unborn Children have well recognized legal statures and rights. Rights exist in persons or legally recognized entities. Since Unborn Children affected by abortion were not represented in *Roe*, as they were entitled to be, see *McArthur v. Scott, supra*, 113 U.S. at 391-392, 395, 404, that decision is void as violative of the Due Process Clause of the 5th Amendment to the Constitution.

b. No Personal Jurisdiction Over Abortion "Survivor" Children or Unborn Children. Neither the 3-Judge District Court nor this Court in *Roe* had personal jurisdiction over Abortion "Survivor" or Unborn Children. Yet such Children were affected personally and vitally by such proceedings and had the right to be before the Courts through their representatives. Since they were not, the District Court and this Court lacked jurisdiction to pronounce judgments affecting them personally. Accordingly, the judgments of such Courts are void as violative of fundamental principles of personal jurisdiction and constitute life, liberty and property deprivations of such Children without due process of law, in violation of the Due Process Clause of such 5th Amendment.

c. Invidious Discriminations Against Unborn Children. With *Roe*, this Court discriminated invidiously against Unborn Children as to 14th Amendment personhood as compared to corporations and the nonaborted born. This operated to deprive such Children of life, liberty and property without due process of law, in violation of the Due Process Clause of such 5th Amendment.

Corporations, which are *artificial* beings, have long been considered "persons" under the Due Process and Equal Protection Clauses of said 14th Amendment, while *natural* and *living* unborn human beings, recognized in law and possessive of substantial legally cognizable rights, are not. The Constitution does not even *mention* corporations. Yet the "Blessings of Liberty" were intended to be *secured* to the "People" of this Nation and to *their* "Posterity", see Preamble to the Constitution, and the Constitution protects the life and other rights of persons against federal and state deprivations without due process of law, above. A prematurely born Child of 7 gestational months has 14th Amendment "personhood", while an older and more developed Unborn Child of 8 gestational months does not. Such discriminations are invidiously discriminatory and violate the Due Process Clause of such 5th Amendment.

d. Naked Deprivation of the Legally Cognizable Rights of Abortion "Survivor" Children and Unborn Children. The Due Process Clause of the 5th Amendment stood as a bar to the Decision and Judgment in *Roe* which endangered the life and other rights of Abortion "Survivor" Children and authorized the destruction of the life and other rights of Unborn Children. This constituted nothing but a naked destruction of the life and other rights of the such Children in this Nation, in violation of the Due Process Clause of such 5th Amendment.

Abortion "Survivor Children are U.S. Citizens and possess a wide array of property and other rights, including the right to continue to live, to support, etc. They have rights under the Due Process Clause of the 5th Amendment not to be deprived of their lives, liberties or

properties by this Court without due process of law. *Roe* is a contradiction of due process.

Unborn Children have legal statuses and substantial legally cognizable rights under statutory and case law, but these rights are subject to destruction by exercise of the abortion "right" of *Roe*. For example, an Unborn Child is recognized under the prenatal tort injury doctrine, with a duty of care owed to such Child [*Yandell v. Delgado*, 471 S.W. 2d 569 (Tex. 1971); Prosser, *Handbook of the Law of Torts* (4th ed., 1971), §55, pp. 335-338], and is entitled to be represented in proceedings in which he or she is affected [*McArthur v. Scott, supra*, 113 U.S. at 391-392, 395, 404. A pregnant woman may be required to undergo a lifesaving blood transfusion for herself and her Unborn Child [*Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson*, 201 A. 2d 537, 538 (S.C. N.J., 1964), *cert. denied*, 337 U.S. 985 (1965)], and a lifesaving caesarean section [*Jefferson v. Griffin Spaulding Co. Hosp. Authority*, 274 S.E. 2d 457, 459, 460 (S.C. Ga., 1981)]. An Unborn Child is dependent upon his father as well as his mother for support within the meaning of the Longshoremen's and Harbor Workers' Compensation Act, 33 U.S.C. §901 *et seq.* [*Tex. Employers' Ins. Co. v. Shea*, 410 F. 2d 56, 61, 62 (5th Cir. 1969)], and, under the "living with" provisions of the Social Security Act, Subchapter II, 42 U.S.C. §401 *et seq.*, "is sufficiently 'in being' to be capable of 'living with' the father at the time of his [the father's] death" [*Wagner v. Finch*, 413 F. 2d 267, 268-269 (5th Cir. 1969)]. A remainder interest in real property may vest in an Unborn Child [*Crisfield v. Storr*, 36 Md. 129, 146 (Ct. App. Md., 1872)]. So too with a beneficial interest under a trust [*Medlock v. Brown*, 136 S.E. 551, 553 (S.C. Ga., 1927)]. In Texas, an

Unborn Child is entitled to take a wrongful death award on the death of his father [see *Brantley v. Boone*, 34 S.W. 2d 409, 411 (Tex. Civ. App. – Eastland 1931, no writ)], and may take, as a posthumous child, an interest under the will of his or her father or an intestate share where there is no will [*Tex. Probate Code*, §§41(a), 67(b)]. Other States accord the same or similar treatment to posthumous children.

e. Unlawful Manufacture of the "Liberty" of Abortion. Finally, the Court exceeded its jurisdiction under Article III, §2, of the Constitution when it *manufactured* unlawfully a "liberty" to abort and, in the process, deprived and limited the States of *their* reserved authorities under the division of powers concept of the 10th Amendment to the Constitution to legislate, etc. in this traditional area of interest. See, in a different context, *Erie R. Co. v. Tompkins, supra*, 304 U.S. at 77-78, 79-80. See Section III-A-1, pp. 13-14, above.

B. *Roe* Should Be Reconsidered and Overruled, Etc. For the reasons and authorities set forth in Section III, above, the Court should reconsider and overrule *Roe* and, in the process, hold that an Unborn Child is a person covered by the 14th Amendment to the Constitution.

CONCLUSION

For the reasons and authorities set forth, above, Amicus Curiae submits respectfully that the Court should reverse the Judgment of the Court of Appeals and render judgment that the Nebraska statutory law under challenge herein is constitutional. In addition, Amicus submits that the Court should not establish a right for partial birth abortions; that it should not extend the abortion "right" of *Roe* to such an area; and that it should reconsider and overrule *Roe* and hold that an Unborn Child is a person under the 14th Amendment to the Constitution.

Respectfully submitted,

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In The

Supreme Court Of The United States

DONALD STENBERG, *ETC., ET AL,*

Petitioner,

v.

LEROY CARHART, *ETC., ET AL.*

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIÆ* AND BRIEF *AMICUS CURIAE* OF THE NATIONAL ASSOCIATION FOR THE PROTECTION OF UNBORN CHILDREN IN SUPPORT OF PETITIONER

With Appendix

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MOTION FOR LEAVE TO FILE *AMICUS CURIÆ* BRIEF

Amicus Curiæ THE NATIONAL ASSOCIATION FOR THE PROTECTON OF UNBORN CHILDREN (hereinafter, NAPUC) moves this court for leave to file an *amicus curiæ* brief on the grounds that NAPUC wishes to bring to this court's attention relevant matter that has not, or will not, be brought to this court's attention by the parties.

This court has held that a person whose life is, or may be, subject to forfeiture should have all of the assistance that may be available. *Franklin v. Lynaugh*, 487 U.S. 164 (1988); *Hitchcock v. Dugger*, 481 U.S. 393 (1987); *Skipper v. South Carolina*, 476 U.S. 1 (1986); *Eddings v. Oklahoma*, 455 U.S. 104, 114 (1982); *Green v. Georgia*, 442 U.S. 95 (1979); *Lockett v. Ohio*, 438 U.S. 586 (1978); *Hunter v. Florida*, 416 U.S. 943 (1974). Allowing *amicus curiæ* at this stage assures a full review of the issues and is fair in a case where the lives of millions of innocent unborn and partially born children are at stake.

The Interest of *amicus curiæ* is set forth at page 1 of the Brief. Counsel has contacted all parties. No party has provided consent as of this writing.

Dated: February 24, 2000.

Respectfully submitted,

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STATEMENT OF INTEREST[1]

Amicus is an unincorporated association, newly formed, for protection of unborn and partially born children. It shares the views of its counsel who has taken an oath to uphold and defend the Constitution of the United States and to defend the poor, downtrodden, and oppressed. He has presented similar *Amicus Curiæ* Briefs on behalf of other states.[2] He is a former professor of Law, University of Northern California, Lorenzo Patiño School of Law. He is affiliated with, but does not represent, a number of pro-life groups and has himself concentrated his practice in the areas of Civil Rights Law, Human Rights Activities, Constitutional Law, and Criminal Defense. He has written two articles on Abortion entitled: ABORTION AND INALIENABLE RIGHTS IN AMERICAN JURISPRUDENCE: A PROSPECTIVE POLICY (©1989); Lynch, *"Posterity", A Constitutional Peg for the Unborn*, 45 AJJ 401 (Notre Dame Law School. 1995). He lived four years in England where he engaged in a self-directed study of the English Political System from the inception of the *Magna Carta* (1215). He is a graduate of McGeorge School of Law (1978).

This case touches and concerns the continuing validity of *Roe v. Wade*, 410 U.S. 113 (1973) and its *progeny*, and, as

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[1] Counsel for NAPUC authored this brief in its entirety. No person or entity, other than NAPUC, its associates, its supporters, or its counsel, made a monetary contribution to the preparation or submission of this brief.

[2] *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989) (For Appellant); *Ohio v. Akron Reproductive Center*, 110 S.Ct. 2972 (1990)) (For Appellant); *Hodgson v. Minnesota v. Hodgson*, 497 U.S. 417 (1990) (For Minnesota; 2 Briefs); *Turnock v. Ragsdale*, 503 U.S. 916 (1992) (Dismissed; after tentative opening brief submitted to ACLU for review prior to filing) (For Appellant); *Bray v. Alexandria*, 113 S.Ct. 753 (1993) (For Petitioner). Counsel has also presented an amicus brief in other unrelated cases. *Walters v. NARS* (*amicus curiæ* Andrew Groza), 473 U.S. 305 (1985); *Dickerson v. USA* (*amicus curiæ* Rutherford Institute), No. 99-5525 (Pending)

such, a decision herein will affect not only the laws of the State of Nebraska, but all of its sister states and territories of the United States. This Court's *amicus* is concerned about the inclusion of unborn and partially born children as present members of "Posterity" in the Preamble of the Constitution, and is concerned, and has been concerned for some time, that unborn children have been unrepresented or underrepresented in court in the years of litigation that have followed *Roe* in 1973. Counsel was convinced then, and *Amicus* is convinced now, that the Court was misled as to the meaning of "personhood." It is *amicus curiæ*'s belief that unborn and partially born children are present members of "Posterity" in the Preamble of the Constitution, and it is imperative, for the preservation of a basic respect for human life and the values enshrined in the Constitution of the United States, that these children be recognized as present members of "Posterity" entitled to protection.

SUMMARY OF ARGUMENTS

1. Unconstitutional conduct cannot be justified by widespread and long use. With respect to the Constitution, *stare decisis* is of less importance than in other areas, and therefore, the holding of *Roe v. Wade* and its *progeny* is not necessarily binding on this Court, and in fact should be rejected for reasons set forth hereinafter.

2. Neither the 5th nor 14th Amendment define personhood. This court has recognized aliens and artificial persons as entitled to protection; therefore it is an anomaly not to find unborn and partially born children are entitled to protection. The most logical place to look for meaning is the Preamble because, while it does not create rights, it defines for whom the rights were created. From a reading of the Preamble, and the term "Posterity," a reasonable construction includes unborn and partially born children as present members of "Posterity." It is consistent with the intent of the framers, and a common law understanding, that unborn and partially born children were persons in being, therefore persons protected by the Constitution. Because this was overlooked in *Roe v. Wade*, *Roe v. Wade* and its *progeny* must be overruled as unsound in principle, unworkable in practice and contrary to the intent of the framers.

3. The court failed to join an indispensable class of persons, unborn and partially born children, and appoint a *guardian ad litem* to advocate their rights, and therefore the decision below must be reversed.

4. Based upon the foregoing, this court should overrule *Roe v. Wade*, 410 U.S. 113 (1973) and its *progeny*, reverse the decision of the court below and remand for further proceedings not inconsistent with this Court's views.

ARGUMENTS

I.

STARE DECISIS IS LESS BINDING ON THIS COURT IN CONSTITUTIONAL ISSUES DESPITE LONG STANDING AND WIDESPREAD PRACTICE; *ROE* AND ITS *PROGENY* DID NOT CONSIDER THE TERM "POSTERITY" IN THE PREAMBLE OF THE CONSTITUTION

Statutes or practices inconsistent with the Constitution, however pervasive, cannot create a power that the Constitution does not bestow, nor furnish a construction that the Constitution does not warrant. *Field v. Clark*, 143 U.S. 649 (1891); 3 Rotunda, Treatise on Constitutional Law § 23.33, p. 512 (1986). This Court invalidated in part its own Rules of Court which were in part based on a Congressional Statute requiring attorneys to take an oath with respect to their activities before the end of the Civil War, when it was pointed out that the provision was in fact unconstitutional. *Ex Parte Garland*, 4 Wall. 333 (1867). Faced with the constitutionality of "separate but equal" facilities, a practice in existence throughout the south, and sanctioned by this Court for 58 years, this Court nonetheless correctly overruled *Plessy v.*

Ferguson, 163 U.S. 537 (1896) in *Brown v. Board of Education*, 347 U.S. 483 (1954) (*Brown I*). *Accord, Bolling v. Sharpe*, 347 U.S. 497 (1954). Moreover, where the importance of the question is great, and touches sensitive issues which need to be resolved, this Court has not allowed the fact that some issues were not properly addressed in the courts below to prevent further argument on the issues omitted so that the continuing controversy could be settled. *Brown I*, 347 U.S., at 489, 496 (1954); *Brown v. Board of Education.*, 349 U.S. 294, 298 (1955) *(Brown II)* (for remedy).

The [*Planned Parenthood v.*] *Casey*[, 505 U.S. 833 (1992)] court noted that *Roe*[3] stood at the intersection of two lines of decisions. One, typified by *Griswold v. Connecticut*, 381 U.S. 479 (1965), are those cases which found a right to privacy in which the state had no right to interfere with personal choices regarding sex,[4] family, and whether to bear and

[3] Interestingly, the *Roe* citations in support of a woman's right to privacy simply do not support an absolute right to privacy. Indeed, in what appears now to be a false first step, this Court observed the right to privacy was first noted in 1891, citing a case that had nothing to do with a constitutional issue. *Union Pacific v. Botsford*, 141 U.S. 250, 251 (1891); but *cf. Sibbach v. Wilson & Co.*, 312 U.S. 1, 11 (1940). *Sibbach* teaches that *Botsford* was not a substantive rule of constitutional law of privacy, but rather, one of statutory construction. In 1891, there was no authority for a physical examination of a plaintiff, a legislative omission cured by the Federal Rules of Civil Procedure, Rule 35, which was no affront to privacy because the plaintiff voluntarily advanced the issue by bringing suit.

[4] The court has not been consistent with respect to sex. In *Bowers v. Hardwick*, 478 US. 186 (1986) this Court held that the right of privacy may not be relied upon by consenting adults in their own bedroom to engage in homosexual conduct forbidden by state law. No case has held that a woman, based on her right to privacy, can do whatever she wishes with her body. Acts of prostitution, even in the privacy of her own bedroom, may be in violation of state law and said law is still Constitutional. *A fortiori*, if unborn and partially born children are persons in the constitutional sense, it is not possible that a woman has an absolute right to take the child's life.

beget children. *Casey*, 505 U.S., at 857. The other line of cases found there exists a certain individual autonomy that limited governmental power regarding medication and the right to die, which supports the *Roe* conclusion. *Ibid.* The *Casey* plurality suggests that *Roe* might be *sui generis*, *i.e.*, one of a kind, but since there had been no erosion of its central premise, noting the change in membership and squabbling among the justices, even if the court were to assume error by *Roe*, "it only went to the strength of the state interest in fetal protection, not to the recognition by the Constitution of the woman's liberty." *Casey*, 505 U.S., at 858-59. The soundness of *Roe*, said the *Casey* Court, was apparent from a consideration of the alternative. "If indeed, the woman's interest in deciding whether to bear and beget a child had not been recognized in *Roe*, the State might as readily restrict a woman's right to choose to carry a pregnancy to term as to terminate it, to further asserted state interests in population control, or eugenics, for example." *Casey*, 505 U.S., at 860. After a review of *stare decisis*,[5] the lack of anything new regarding the status of unborn children, and in view of widespread reliance, *Casey* abandoned *Roe's* trimester periods, and affirmed both women's rights and the "State's interest in protecting human potentiality" after viability, provided there was no undue burden on a woman's choice. *Ibid.*

Casey begs important questions. The central issue is not whether a woman has a right to decide whether to beget children; of course she does. And of course there is no issue as to termination of a pregnancy; all pregnancies will terminate at the end of term, by natural birth, caesarian section, or otherwise. The issue is: whether a woman has the right to choose to terminate a pregnancy that terminates the life of an unborn or partially born child once begot. The *Roe* Court reached the result it did because, it said, Texas had failed to

[5] Justice O'Connor conceded there was an erosion of support by the justices as to the continued validity of *Roe*.

demonstrate where in the Constitution unborn children were Constitutional persons. 410 U.S., at 157-59.[6] *Casey* perpetuates the *Roe* error on the basis there has been no development in constitutional theory that undermines the *Roe* premise. Neither opinion addresses the Preamble,[7] nor its meaning. Furthermore, there has been a growing recognition that this court erred. Comments, *To Be and Not to Be: Inconsistencies in the Law Regarding the Legal Status of the Unborn Fetus*, 71 Temple Law Review 963, 994 (1998) (hereinafter, *To Be and Not to Be.)*; Notes, *Fourteenth Amendment Personhood; Fact or Fiction?*, 73 St. John's Law Review 495, 530-40 (1999) (hereinafter, *Fourteenth Amendment Personhood);* Lynch, *"Posterity": A Constitutional Peg for the Unborn*, 45 AJJ 401 (1995) (hereinafter, *Lynch*).

This court can judicially notice its own docket and the judiciary, which has been impacted by abortion cases, and that its opinions have been heavily criticized as being unsound in principle and unworkable in practice. *To Be and Not to Be*; *Fourteenth Amendment Personhood, supra* ("our judiciary is dishonest in its treatment of fetuses"); Lynch, *supra*. Similarly, it is well known that the abortion controversy has led to disorder in the streets throughout the country.[8] Moreover, beginning with *Webster v. Reproductive Health Services*, 492 U.S. 490, 518-519 (1989) (Rehnquist, Ch. J.), this court has increasingly found *Roe* to be unsound

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[6] A reading of the Petition, Response, and Briefs by the parties and *amicus* in *Roe* shows the primary focus was on the term person as found in the 5th and 14th Amendments. 75 LANDMARK BRIEFS AND ARGUMENTS OF THE SUPREME COURT OF THE UNITED STATES.

[7] Douglas mentioned "liberty" in the Preamble, but that was hardly an exposition on the meaning of "Posterity" in the Preamble.

[8] It is not suggested that this disorder is the reason for overruling *Roe*. Quite the contrary, the reason is unborn and partially born children are persons who are present members of "Posterity" in the Preamble of the Constitutional. The mention of this problem is but recognition that the problem must be resolved.

in principle and unworkable in practice. In fact, a proper reading of the Preamble *in pari materia* with the body of the Constitution leads to this realization:

A person is created at conception. Preamble.

A person becomes a citizen at birth. 14th Amend., § 1.

A citizen can vote at age 18. 26th Amend., § 1.

Thus, this Court should now recognize, in light of the above, that it has retreated from *Roe v. Wade*, 410 U.S. 113 (1973), and in light of the arguments to follow, should now overrule *Roe* and its *progeny* prospectively, and remand for further proceedings in light of the fact that unborn and partially born children are present members of "Posterity" in the Preamble, thus persons entitled to protection; or remand for consideration by the lower courts as to whether unborn and partially born children are present members of "Posterity" entitled to protection.[9]

II.
UNBORN AND PARTIALLY BORN CHILDREN ARE PERSONS IN THE CONSTITUTIONAL SENSE BY VIRTUE OF THEIR INCLUSION AS PRESENT MEMBERS OF "POSTERITY" IN THE PREAMBLE OF THE CONSTITUTION

Neither the 5th nor the 14th Amendment defines person. The 14th Amendment defines citizenship.[10] In other contexts, the court has held that aliens[11] and artificial persons[12]

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[9] Nebraska raised personhood below as being found in the 14th Amendment, and this court denied *certiorari* on this issue. This brief deals with personhood as found in the Preamble. A slip of the pen ought not foreclose Nebraska from amending its argument. Indeed, this court has held that appellate courts cannot ignore the correct law, regardless of the law and facts relied on below.

[10] "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, ..."

[11] *E.g., Hampton v. Mow Sun Wong*, 426 U.S. 88 (1976); Const., Art. VI, Treaty Clause; McKechnie, *Magna Carta*, Art. 41 (Aliens).

are persons entitled to Constitutional protection. Not to recognize unborn and partially born children as a person is therefore an anomaly. As "Person," is used without qualification, the most logical place to look for meaning is the Preamble,[13] because while its purpose is not to create rights,[14] it does define for whom the rights were created.[15] The Preamble reads:

> "We, the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defense, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America." Appendix, p. A6.

The words "people of the United States" and "citizens" are synonymous terms.[16] The Preamble creates two classes

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[12] See Chicago B. & Q. R.R. Co. v. Iowa, 94 U.S. 155 (1877); *E.g.*, *Land v. Dollar*, 330 U.S. 731 (1947) (*Replevin*; Stock taken under color of federal law).

[13] The first record that a sovereign rules with the consent of the governed appears to be I Sam. 16, II Sam. 5, 9-20, I Kings 1-2. When David's father died, he ruled over the seven tribes of Judah for seven years. Then the elder of Israel met with Davit at Hebron, and they made a contract for David to rule them as well. Thereafter David ruled over all of Israel and Judah for forty years. Other codes, most notably the Code of Hammurabi, were in writing, but were unilateral acknowledgments of human rights. The *Magna Carta*, *infra*, appears to be the first written document executed by both the sovereign and its subjects. The Constitution abolished traditional sovereignty, placed sovereignty in the People, signed by their representative, and ratified by them according to their respective state procedures.

[14] Scott v. Sanford, 60 U.S. (19 How.) 404 (1857); Cruikshank, supra, 92 U.S. (2 Otto), 542, 549. The 13th & 14th Amendments do not overrule Scott, but only remove the limitations found, thus enlarging the class of persons who are citizens.

[15] *Scott v. Sanford*, 60 U.S. (19 How.) 404 (1857); *Cruikshank*, *supra*, 92 U.S. (2 Otto), at 549.

[16] *Scott v. Sanford*, 60 U.S. (19 How.) 404 (1857); *Cruikshank*, *supra*, 92 U.S. (2 Otto), 542, 549

of sovereignty, "ourselves" and "our Posterity."[17] Its purpose appears to be to include "Posterity"[18] on an equal footing with, and having the same rights as, "ourselves" as evidenced by the parallel structure of the phrase. Therefore, "Posterity" as to those who are lives in being is synonymous, if not with "citizenship," [19] surely "personhood." [20] This understanding is consistent with an understanding of the meaning of "Posterity" in 1787.[21] In 1644, in a well known pamphlet, it was argued that "Parliament could no more censure the issue of the mind than it could the issue of the womb." [22] At common law, certain members of future generations, unborn and partially born children,[23] were lives in being for the purposes of the Rule Against Perpetuities. [24] Moreover, prenatal injuries were to a limited extent recognized at Common Law,[25] and it

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[17] ABORTION AND INALIENABLE RIGHTS, etc, supra, at page 1.

[18] "Posterity" is capitalized in the original. As a noun is capitalized only if it identified a particular person, place, or thing, it implies the framers considered the word important

[19] See footnote 9, supra. It is probably more accurate to say unborn, partially born, children are persons who becomes a citizen (§ 1, 14th Amendment), except that the right to vote comes at age 18. (26th Amendment)

[20] See footnotes 4 and 12

[21] ABORTION AND INALIENABLE RIGHTS, etc, supra, at page 1.

[22] Milton, AREOPAGITICA (1644).

[23] Aristotle, *Politics*, VII, 1335b, 24-26; Aquinas, *Summa Theologiæ*, 1, q. 76, a. 5 and q. 118; Noonan, CONTRACEPTION, 86-88 (Harv. U. Press, 1965). The Old Testament provided a remedy against persons causing a miscarriage. Exodus 21:22. It is not repugnant to the 1st Amendment Establishment Clause merely because civil law corresponds to the tenets of some religions. *E.g., Witters v. Washington Dept of Social Svcs for the Blind*, 474 U.S. 481 (1986).

[24] Gray, *The Rule Against Perpetuities* (4th Ed.); *Alamo School Dist. v. Jones*, 182 Cal.App.2d 180, 6 Cal.Rptr. 272 (1960).

[25] "To kill a child in its mother's womb is now no murder, but a great misprision: but if the child be born alive and die by reason of the

does not appear that tort actions for the injuries were barred.[26] Had the framers used "and our heirs", it would have created the equivalent of a fee simple absolute with powers of alienation, [27] a concept clearly inconsistent with the concept of "unalienable rights" in the Declaration of Independence[28] and the concept of an "indestructible and perpetual union"[29] in the Preamble, whereas if construed as a fee tail,[30] it would be consistent with an intent to create "unal-

potion or bruises it received in the womb, it is murder in such as administered or gave them." Lord Coke, repeated by Blackstone at Book IV, p. 198. His reasoning may have been influenced by (1) "No man shall be taken or imprisoned upon the appeal of a woman, for the death of any other than her husband." *Magna Carta* (1215), Art. 54. As her unborn child was not her husband, obviously, there was a failure of evidence. (2) medical knowledge as to unborn children was quite primitive when compared to modern medical knowledge.

[26] *Sinkler v. Kneale*, 401 Pa 267, 164 A.2d 93, 94 (1960); *McIntosh v. Dill*, *supra*, 205 P. 917 (1922)); Halsbury's Laws of England (1st Ed, 1911) Infants §§ 132, 135.

[27] *White v. Hart*, 80 U.S. (13 Wall.) 646, 650 (1872). Other constructions result in a power of alienation inconsistent with unalienability: contingent remainder, Gray, THE RULE AGAINST PERPETUITIES (4th Ed.); *Alamo School District v. Jones*, 182 Cal.App.2d 180, 6 Cal.Rptr. 272 (1960); the rule in Shelly's Case, 31 *Corpus Juris Secundum*, Estates § 4.

[28] "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, ... that Governments are instituted among Men, deriving their just powers from the consent of the governed, ..." American Declaration of Independence, § 2; Schwartz, THE BILL OF RIGHTS, A DOCUMENTARY HISTORY.

[29] *White v. Hart*, 80 U.S. (13 Wall.) 646 (1872) construing Preamble.

[30] *Hertz v. Abrahams*, 110 Ga. 707, 36 S.E. 409 (1900); *Haward v. Howe*, 12 Gray (Mass.) 49 (1858); *Gannon v. Albright*, 183 Mo. 238, 81 S.W. 1162 (1904); *Kay v. Scates*, 37 Pa 31 (1860); *Larew v. Larew*, 146 Va. 134, 135 S.E. 819 (1926); 28 AMERICAN JURISPRUDENCE, Second, Estates, § 53. *Cf., Barber v. Pittsburgh, F.W. & C.R. Co.*, 166 U.S. 83 (1897); *Anderson v. United Realty Co.*, 79 Ohio St. 23, 86 N.E. 644, affmd 222 U.S. 16 (1911), (recognizing by *dictum* common law rule). The Constitution concerns estates and interests in land. Art. I, Sec. 8, cl. 17 (District of Columbia; Places purchased); Art. III, Sec. 3, cl. 2 (for-

ienable rights" and a "perpetual union," [31] for the protection of future generations, including unborn and partially born children.

The Constitution was submitted to the People for ratification.[32] Implicit in the Preamble is the concept that the Constitution is to be a social contract[33] wherein society promises the individual unalienable rights, in return for which the individual promises to conform to the laws of society which do not derogate[34] from unalienable rights. Mutual promises have always been considered sufficient consideration for enforceability.[35] As persons under the age of capacity[36] could not consent,[37] it appears the framer's intended that adults were of the class "ourselves," and all others of the class "Posterity,"[38] to include lives in being, *i.e.* unborn and partially born children.

Taking the approach that unborn and partial born children are present members of "Posterity" answers a number of

feitures); Art. IV, Sec. 2, cl. 1 (privileges and immunities), Sec. 3, cl. 2 (property of the United States); Amendment III (Quartering of soldiers); Amendment IV (Secure in . . . Houses); Amendment V (nor be deprived of . . . property . . . nor shall private property be taken. . . .")

[31] *White v. Hart*, 80 U.S. (13 Wall.) 646 (1872) construing Preamble.

[32] 2 Farrand, Max, The Constitutional Debates, pp. 152, 163, 177, 193, 196, 209, 565, 582, 590, 651; 3 Rotunda, op cit., p. 663, note 1.

[33] E.g., Hobbes, LEVIATHAN (1651); Locke, SECOND TREATISE OF GOVERNMENT (1690); Laqueur, THE HUMAN RIGHTS READER (1979).

[34] Verdross, *Forbidden Treaties In International Law*, 31 AJIL 571 (1937); *Id, Jus Dispositivum & Jus Cogens In International Law*, 60 AJIL 55 (1966).

[35] Chitty on Contracts (23rd Ed, 1968) 134; Restatement, Contracts (1st) § 77; *Coggs v. Berherd*, 2 Ed.Raym. 909 (1703).

[36] "The right of citizens of the United States, who are eighteen years of age or older, to vote shall not be denied or abridged by the United States or by any State on account of age." 26th Amend, § 2.

[37] Chitty on Contracts.

[38] 2 Stephens Commentaries 342 (1841).

theoretical problems. *Casey*, 505 U.S. at 860. (O'Connor, J.) First, it is further development of constitutional theory recognizing there is not just one right, or more precisely - life, at stake, but two, the mother's, a member of "ourselves," and her unborn or partially born child's, a present member of "Posterity." Second, it supports the proposition the State cannot force women to terminate pregnancy or engage in eugenics, because her unborn or partially born child is a person entitled to protection. Third, it sets a standard that termination of a pregnancy occurs as a result of natural birth, or based on necessary medical intervention for the preservation of both lives. Fourth, it assures a woman's right to seek medical intervention to preserve both lives, if possible, without undue state influence. Fifth, it takes the courts out of the quagmire of trying to guess when unborn and partially born children become "viable" and therefore entitled to protection. With conception, there is no guesswork. Finally, it does justice by respecting the Constitutional guarantee to protect human life.

III.

THE STATES HAVE A RIGHT TO REASONABLE REGULATIONS FOR THE PROTECTION OF UNBORN AND PARTIALLY BORN CHILDREN

The Constitution Provides, in relevant part:

> "No person shall be, ... deprived of life ... without due process of law." U.S. Constitution, 5th Amendment.

Neither a State nor the federal government may utilize tax money to take life without due process of law.[39] *E.g.,*

[39] Under international law, a state has the obligation to provide police protection for its citizens at home. (Verdross, *Forbidden Treaties International. Law*, 31 AJIL 571 (1937); Verdross, *Jus Dispositivum & Jus Cogens in International. Law*, 60 AJIL 55 (1966)). Protecting an individual through due process in American jurisprudence is derived from the *Magna Carta* (1215). *Murray's Lessee v. Hoboken Land & Improvement Co.*, 59 U.S. (18 How.) 272 (1856). McKechnie, *Magna Carta*; the Great Charter of King John. McKechnie is the recognized scholar on the *Magna Carta*. 10 Halsbury's Statutes of England (4th Ed) Constitutional Law, 25 Edw. 1 *(Magna Carta)*(1297), p. 14, Notes, ¶ 2.

Flash v. Cohen, 392 U.S. 83 (1968). Assuming, *arguendo*, that unborn and partially born children are present members of "Posterity," they have a right to representation, 2 Stephens Commentaries 342 (1841); *McIntosh v. Dill*, *supra*, 205 P. 917 (1922); 17 Halsbury's Laws of England, Infants §§ 132, 135 (1st ed, 1911), to be heard on the question as to whether their lives should be terminated. *See generally, Mullane v. Central Hanover B&T*, 339 U.S. 706 (1950); *Furman v. Georgia*, 408 U.S. 238 (1972), and it *progeny*; *Cruikshank*, *supra*, 92 U.S. (2 Otto), at 549.

Unborn or partially born children have all of the characteristics of life.[40] *See generally, To be and not to be, supra*; *Fourteenth Amendment Personhood, supra*, 72 St. John's L.R., at 534-39; Lynch, *supra*. Whether or not it can be ascertained at any point in time that unborn or partially born children are human is absurd; if the parents are human they cannot be anything but human.[41]

Given a state's obligation to ensure life is not taken without due process of law, the state has a legitimate interest

[40] Case & Steirs, BIOLOGY; OBSERVATION & CONCEPT:, p. 110 (1971), excretion, pp. 122, 141, 143, 149-150; ingestion, pp. 70, 80; respiration, pp. 8, 51, 64, 77; irritation, pp. 267, 329, 330; reproduction, pp. 122, 163-165, 298-299, 327, 329. A zygote has an individual developing life that is viable in *utero*, in contradistinction to the ovum and sperm which are not. Id, pp. 324-327. See next footnote.

[41] The fact that the zygote is not viable extrauterine does not negate the fact of its life. All life is environmentally dependent. No one would seriously consider sending an astronaut tied to an "umbilical cord" on a space walk to test whether or not the astronaut was a life by cutting the umbilical cord to see if the astronaut could survive; such a proposition is absurd. Similarly, a fetus securely within the womb will die if there is an abruption of the placenta. Jacobs, et al, MDs, OBSTETRICS AND GYNECOLOGY, FAMILY HEALTH & MEDICAL GUIDE (1979), page 93.

in denying the absolute right to take the life of unborn or partially born children. Its citizens, and the citizens of every state, have an interest in ensuring that there exist safeguards so that unborn and partially born children do not become victims of genocide. (*E.g.*, *International Convention on the Prevention and Punishment of the Crime of Genocide*, Congressional Digest, December 1984; U.S. Const., Art. VI, cl. 2 (treaties).[42] Accordingly, any opinion that states otherwise is void as being repugnant to the doctrine of *jus cogens*.

One last problem remains. Below, Nebraska asserted that partially born children were "persons," in view of the 14th Amendment. In fact, they are present members of "Posterity." As the issue of personhood was in fact raised, a slip of the pen should not foreclose this Court from considering that issue. The Court has options. It can order supplemental briefing on the arguments, or reverse and remand on this issue to allow the parties to develop the issue below in order to allow this court the benefit of discussion.

IV.

NON-JOINDER AND FAILURE TO APPOINT A *GUARDIAN AD LITEM* REQUIRES REVERSAL

The Federal Rules of Civil Procedure, Rule 19,[43]

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[42] Clearly, the Constitution implicitly recognizes the right to privacy. U.S. Const., 2d Amend. (Quartering of soldiers), and 4th Amend. (search and seizure); *Katz v. United States*, 389 U.S. 347 (1967), and its progeny. But it is equally clear that a person cannot use the right of privacy and the right to do with one's body what he or she wishes if the conduct amounts, under state law, to a crime. *Bowers v. Hardwick*, 478 U.S. 186 (1986).

[43] **"(a) Persons to be joined if Feasible.** A person who is subject to service of process and whose joinder will not deprive the court of jurisdiction action shall be joined as a party in the action if ... (2) the person claims an interest relating to the subject of the action and is so situated that the disposition of the action in the person's absence may (i) as a practical matter impair or impede the person's liability to protect that interest or (ii) leave any of the persons already a party subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations by reason of the claimed interest. If the person has not been so joined, the court shall order that the person be made a party. * * * *"**(b) Determination by Court Whenever Joinder Not Feasible.** If a person as described in (a)(1) - (2) hereof cannot be make a party, the court shall determine whether in equity and good conscience the action should proceed among the parties before it, or should be dismissed, **the absent party being thus regarded as indispensable**. The factors to be considered by the court include: first, to what extent a judgment rendered in the person's absence might be prejudicial to the person or those already parties; . . . . [Emphasis added]"

provides, in relevant part, that persons whose interests as a practical matter would be impaired by their absence should be joined. Certainly, this is a case where the lives of millions of innocent unborn and partially born children are at stake. Further, Rule 17,[44] in relevant part, provides that the court should appoint a *guardian* for infants and incompetents. Such is the case at bar. The court below should have appointed an advocate for the protection of unborn and partially unborn children.

At common law, with few exceptions, the tenant in possession of a fee tail could be enjoined from alienation by those with a right to inherit. Moreover, a *guardian ad litem*, a guardian appointed by a court, could prosecute or defend for an infant in any suit to which he may be a part, 2 Stephens Commentaries 342 (1841), or by the State acting in *Parens patriae*. *McIntosh v. Dill*, 86 Okla. 1, 205 P. 917, 925 (1922); 17 Halsbury's Laws of England (1st Ed, 1911), Infants §§ 132, 135. Unborn and partially children had a common law protectable interest. As already noted, *ante* p. 10 *citing* Lord Coke, while it is was not murder to kill a child

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[44] FRCP, rule 17, provides, in relevant part:

"(c) Infants or Incompetent Persons. . . . The court shall appoint a guardian ad litem for an infant or incompetent person not otherwise represented in an action or shall make such other order as it deems proper for the protection of the infant or incompetent person."

in a mother's womb, it was still a great misprision (crime)! Unborn children were a life in being for purposes of the rule against perpetuities. Gray, op. cit. And it does not appear that common law barred tort actions for prenatal injuries, *Sinkler v. Kneale*, *supra*, 164 A.2d 93, 94 (1960), which could be brought by a representative. 2 Stephens Commentaries 342 (1841); *McIntosh v. Dill*, *supra*, 205 P. 917 (1922); 17 Halsbury's Laws of England (1st Ed, 1911) Infants §§ 132, 135.

In the case below, if unborn and partially born children are entitled to constitutional protection, they have an interest in partial birth abortion as it bears on a decision "that might impair or impede their very lives." To suggest that innocent unborn and partially born children have no right to an advocate to defend their lives when we recognize that the condemned have a right to an advocate on review of their death penalty (*e.g., Douglas v. California*, 372 U.S. 353 (1963); *Tison v. Arizona* (1987) 481 U.S. 137) would be absurd. *See generally, To be or not to be, supra*; *Fourteenth Amendment Personhood, supra*; Lynch, *supra*.

The fact of the matter is, that each of the cases cited by the Court below were decided in the absence of a *guardian ad litem* to protect the rights of unborn and partially born children. Accordingly, this court should reverse and remand for proper representation and advocacy if the court is not convinced that it should reach the issue of whether unborn and partially born children are included as present members of "Posterity."

CONCLUSION

Based upon the foregoing, this Court should overrule *Roe v. Wade*, 410 U.S. 113 (1973) and its *progeny* as unsound in principle and unworkable in practice, reverse, and remand for further proceedings not inconsistent with this court's views.

Date: February 24, 2000.

Respectfully submitted,

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APPENDIX
EXCERPTS FROM
Farrand, Max, THE CONSTITUTIONAL DEBATES*

[129]

COMMITTEE OF DETAIL, I

***

[Proceedings of the Convention, June 19 -- July 23.]

[152]

COMMITTEE OF DETAIL, IV

*****

VI

We the People of (*and*) the States of New Hampshire, Massachusetts, Rhode Island and Providence Plantations, Connecticut, New. York, New. Jersey, Pennsylvania, Delaware, Maryland, Virginia, North. Carolina, South. Carolina and Georgia do ordain declare and establish the following Constitution for the Government of ourselves and of our Posterity.

1.

*****

[163]

COMMITTEE OF DETAIL, IX

*****

IX

We the People of the States of New Hampshire, Massachusetts, Rhode-Island and Providence Plantations, Con-

---

* Pages from Farrand's are indicated at the beginning of the page in [ ]. All punctuation and capitalization is exactly as found in Farrand's, which faithfully follows the manuscript originals in Madison's book. All footnotes were omitted unless deemed important to the issues under consideration. The most commonly omitted footnote says "Found among the Wilson Papers and in Wilson's handwriting. Portions in parentheses represent parts crossed out. Italics represent later insertions."

necticut, New-York, New-Jersey, Pennsylvania, Delaware, Maryland, Virginia, North-Carolina, South-Carolina and Georgia do ordain, declare and establish the following Constitution for the Government of ourselves and our Posterity.

1.

*****

[177]

Monday **MADISON** **August 6**

MADISON

Monday August 6th. In Convention

<Mr. John Francis Mercer from Maryland took his seat.>

Mr. Rutlidge <delivered in> the Report of the Committee of detail as follows: < a printed copy being at the same time furnished to each member.>

We the people of the States of New Hampshire, Massachusetts, Rhode-Island and Providence Plantations, Connecticut, New-York, New-Jersey, Pennsylvania, Delaware, Maryland, Virginia, North-Carolina, South-Carolina and Georgia do ordain, declare, and establish the following Constitution for the Government of Ourselves and our Posterity.

Article I

*****

[193]

TUESDAY, AUGUST 7, 1787.

JOURNAL

Tuesday August 7, 1787.

[To refer the report to a Committee of the whole Ayes - 5; noes - 4.

Delaware being represented during the Debate a question was again taken on ye Committee of ye whole Ayes ---

3; noes --- 6.]

On the question to agree to the Preamble to the constitution as reported from the committee to whom were referred the Proceedings of the Convention -- it was passed unan: in the affirmative [Ayes -- 10; noes --- 0.]

*****

[196]

Tuesday **MADISON** **August 7**

MADISON

Teusday August 7th. In Convention

The Report of the Committee <of detail being> taken up

...

******

The <preamble> of the Report was agreed to nem. con. So were Art: I & II.

[209]

Tuesday MCHENRY Augt 7

MCHENRY

Augt. 7.

*****

The preamble or caption and the 1. and 2. article passed without debate, ...

*****

[565]

COMMITTEE OF STYLE

Proceedings of Convention Referred to the Committee of Style and Arrangement.

We the People of the States of New-Hampshire, Massachusetts, Rhode-Island and Providence Plantations, Connecticut, New-York, New-Jersey, Pennsylvania, Delaware, Maryland, Virginia, North-Carolina, South-Carolina and

Georgia do ordain, declare and establish the following Constitution for the Government of ourselves and our Posterity.

ARTICLE I.

*****

[590]

COMMITTEE OF STYLE

Report of Committee of Style

WE, the People of the United States, in order to form

a more perfect union, to establish justice, insure domestic tranquility, provide for the common defense, promote the general welfare, and secure the blessings of liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America.

ARTICLE I.

*****

[604]

THURSDAY, SEPTEMBER 13, 1787.

JOURNAL

Thursday September 13, 1787.

*****

Resolved that the preceding Constitution be laid before the United States in Congress assembled, and that it is the opinion of this Convention that it should afterwards be submitted to a Convention of Delegates, chosen in each State by the People thereof, under the recommendation of it's Legislature; for their asent and ratification.

*****

[604]

*****

[To postpoine the report respecting the 22nd and 23rd Ayes -- 9; noes -- 1.]

*****

To strike out the word "to" before establish justice Ayes --- 8; noes --- 2,]

[641]

MONDAY, SEPTEMBER 17, 1787.

JOURNAL

Monday September 17, 1787.

Detail of Ayes and Noes

	The Constitution Unanimously agreed to.	To deliver over the Journal and papers to the President	
	[567]	[568]	[569]
New Hampshire	Aye	Aye	aye
Massachusetts	Aye	Aye	aye
Rhode Island	Aye	Aye	aye
Connecticut	Aye	Aye	aye
New York	Aye	Aye	aye
New Jersey	Aye	Aye	aye
Pennsylvania	Aye	Aye	aye
Delaware	Aye	aye	aye
Maryland	Aye	aye	no
Virginia	Aye	aye	aye
North Carolina	Aye	aye	aye
South Carolina	Aye	dd	aye
Georgia	Aye	aye	aye

MADISON

Monday Sepr. 17. 1787. In Convention

The engrossed Constitution being read, ...

Docr. Franklin rose with a speech in hand ....

*****

[643]

... --- He then moved that the Constitution be signed ...

*****

[644]

*****

On the question to agree to the Constitution enrolled in order to be signed. It was agreed to by all the States answering ay.

*****

[649]

MCHENRY

Monday Sepr. 1787.

Read the engrossed Constitution. Altered the representation in the house of representatives.

*****

[651]

THE CONSTITUTION
OF THE UNITED STATES

We, the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defense, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America.

ARTICLE I.

*****

MOTION FI)
FEB 2 9 2000

(29)

No. 99-830

Feb 29 2000

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1999

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ of Certiorari to the United State Court of Appeals for the Eighth Circuit

---

MOTION FOR LEAVE TO FILE AN AMICUS CURIAE BRIEF UNDER RULE 37.3(b) WITH ATTACHED BRIEF AMICUS CURIAE OF JAMES J. CLANCY (MEMBER OF THE SUPREME COURT BAR) IN SUPPORT OF NEITHER PARTY, SUGGESTING REVERSAL OF THE JUDGMENT FOR RESPONDENTS FOR LACK OF ARTICLE 3, §2 FEDERAL SUBJECT MATTER JURISDICTION; PURSUANT TO THE AUTHORITY OF THE 11TH AMENDMENT, *WATSON V. BUCK*, 313 U.S. 387 (1941); *YOUNGER V. HARRIS*, 401 U.S. 37 (1971); *HUFFMAN V. PURSUE, LTD.*, 420 U.S. 592 (1975); AND THE *YOUNGER - HUFFMAN* ABSTENTION DOCTRINE.

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Amicus Curiae
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February 28, 2000

115pp

QUESTIONS PRESENTED

Re: Lack of Federal Subject Matter Jurisdiction under the 11TH Amendment, See *Middlesex Ethics Comm. v. Garden State Bar Assn.*, 457 U.S. 423 at 432 and 437, 73 L.Ed.2d 116, 102 S.Ct. 2515 (1982), Infra at page 2; and *Nebraska v. Divis*, 256 Neb. 328, 589 N.W.2d 537 (1999), Infra at Pages 6-9.

I

Whether the Opinion and Judgment of the 8TH Circuit Court of Appeals Abridges the Sovereign Right of the State of Nebraska under the **10TH** and **11TH Amendments to the U.S. Constitution**; as Construed by this Court in ***Watson v. Buck***, 313 U.S. 387 (1941), and the ***Watson v. Buck*** **Abstention Doctrine**, as That Doctrine Has Been Factored into ***Younger v. Harris***, 401 U.S. 37 (1971), and ***Huffman v. Pursue, Ltd.***, 420 U.S. 592 (1975), reh. den., 421 U.S. 971, and the ***Younger*** and ***Huffman*** **Abstention Doctrines**; Which Require That New Legislation (Civil and Criminal) Involving an "Important State Interest"; i.e., Public Morals, Which Can Be Given a Constitutional Construction, must Be Initially Construed and Applied by the Nebraska Judiciary; Which, under the **Doctrine of Separation of Powers** Is Required, Where Possible, to Give the State Statute a "Saving Construction", and Thereby Assist the Nebraska State Legislature in its Effort to Write a State Statute Which Will Meet the Constitutional Requirements of the Federal Judiciary with Respect to the Federal Constitution **?**

II

Whether the U.S. District Court for the District of Nebraska Lacked **Article 3, §2** Subject Matter Jurisdiction of Respondent Carhart's Federal Civil Rights Action for Failure of the Trial Court to Make the Jurisdictional Findings of Fact Required by the **11TH Amendment** and ***Watson v. Buck***, 313 U.S. 387 (1941) and the ***Watson v. Buck*** **Abstention Doctrine**, as Factored into the ***Younger - Huffman*** **Abstention Doctrines** by this Court's Opinions in ***Younger v. Harris***, 401 U.S. 37 (1971) and ***Huffman v. Pursue, Ltd.***, 420 U.S. 592 (1975), Reh. Den., 421 U.S. 971 (1975); Where the State Legislature Has Enacted Legislation Dealing with the Public Crime of "Infanticide" Which Is Engaged in under the Mantra of a Personal Right to an Abortion; and Where Such Important State Legislation on Public Morals Is Not Unconstitutional on its Face and Can Be Constitutionally Construed by the Nebraska Judicial System; Which, Pursuant to the **Doctrine of Separation of Powers** Is under a Constitutional Duty, Where Possible, to Give Such Legislation a Constitutional Construction ?

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MOTION FOR LEAVE TO FILE AN AMICUS CURIAE BRIEF UNDER RULE 37.3(b) IN SUPPORT OF NEITHER PARTY, SUGGESTING A SUMMARY REVERSAL OF THE JUDGMENT FOR THE RESPONDENT CARHART UNDER *STEEL CO. V. CITIZENS FOR A BETTER ENVIRONMENT*, 523 U.S. 83 (1998) FOR LACK OF FEDERAL SUBJECT MATTER JURISDICTION DUE TO THE FAILURE OF THE TRIAL COURT TO MAKE THE JURISDICTIONAL FINDINGS OF FACT REQUIRED BY *YOUNGER V. HARRIS*, 401 U.S. 37 (1971), AND *HUFFMAN V. PURSUE, LTD.*, 420 U.S. 592 (1975).

NOW COMES James J. Clancy, Attorney at Law, and a member of the Supreme Court Bar, to move this Court pursuant to **Rule 37.3(b)** [1/] for leave to file a Brief Amicus Curiae, in support of neither of the Parties, suggesting a summary reversal of the Judgment for Respondent Carhart under ***Steel Co. v. Citizens for a Better Environment***, 523 U.S. 83 (March 4, 1998) for lack of federal subject matter jurisdiction due to the failure of the Trial Court to make the Jurisdictional Findings of Fact required by ***Younger v. Harris***, supra, and ***Huffman v. Pursue, Ltd.***, supra.

The ***Steel Co.*** case is cited for the Proposition of Law which holds that the first duty of every Court is to make a determination whether, under the **U.S. Constitution**, the court has jurisdiction over the subject matter of the action which is before it. It matter not that Attorney General Stenberg did not raise the issue of lack of subject matter jurisdiction in ***Stenberg v. Carhart***, at the trial, or on appeal, or in his Petition to this

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[1/] Consent of all parties was requested and has been denied. See correspondence at **Appendix H** to this Brief Amicus Curiae. No counsel for a party authorized this Brief in whole or in part, and no person or entity, other than the Amicus Curiae, made a monetary contribution to the preparation or submission of this Brief.

Court. It is sufficient that Amicus has, by this Motion, brought the matter to this Court's attention before the Oral Argument in this Court in ***Stenberg v. Carhart***, and has framed the issues in two specific Jurisdictional Questions at **pages i** and **ii** to this Brief. Amicus contends that ***Steel Co.***, supra, requires this Court to consider both Jurisdictional Questions, ***sua sponte***, because of the seriousness of the **11TH Amendment** Constitutional infringement involving ***Watson v. Buck***, 313 U.S. 387 (1941).

The judgment of the U.S. District Court and that of the 8TH Circuit Court of Appeals must be vacated upon the grounds of lack of **Article 3, §2** federal subject matter jurisdiction, pursuant to the **11TH Amendment**; ***Watson v. Buck***, 313 U.S. 387 (1941); ***Younger v. Harris***, 401 U.S. 37 (1971); ***Huffman v. Pursue, Ltd.***, 420 U.S. 592 (1975); and the ***Younger*** - ***Huffman*** **Abstention Doctrines** for failure of the Trial Court to make the specific jurisdictional findings of fact required by ***Younger*** and ***Huffman***, see, in particular, ***Huffman***, 420 U.S. at 611-613 (last three [3] paragraphs of Chief Justice Rehnquist's opinion) reading:

> " Younger, and its civil counterpart which we apply today, do of course allow intervention in those cases where the District Court properly finds that the state proceeding is motivated by a desire to harass or is conducted in bad faith, or where the challenged statute is ' "flagrantly and patently violative of express constitutional prohibitions in every clause, sentence and paragraph, and in whatever manner and against whomever an effort might be made to apply it." ' As we have noted, the District Court in this case did not rule on the Younger issue, and thus apparently has not considered whether its intervention was justified by one of these narrow exceptions. Even if the District Court's opinion can be interpreted as a sub silentio determination that the case fits within the exception for statutes which are ' "flagrantly and patently violative of express

> constitutional prohibitions," ' such a characterization of the statute is not possible after the subsequent decision of the Supreme Court of Ohio in State, ex rel. Ewing v A Motion Picture Film Entitled 'Without a Stitch,' 37 OhioSt.2d 95, 307 NE2d 911 (1974). That case narrowly construed the Ohio nuisance statute, with a view to avoiding the constitutional difficulties which concerned the District Court." (Our emphasis.)
>
> " We therefore think that this case is appropriate for remand so that the District Court may consider whether irreparable injury can be shown in light of 'Without a Stitch', and if so, whether that injury is of such a nature that the District Court may assume jurisdiction under an exception to the policy against federal judicial interference with state court proceedings of this kind. The judgment of the District Court is vacated and the cause is remanded for further proceedings consistent with this opinion." (Our emphasis.)
>
> " It is so ordered."

THE IMPORTANCE OF *SUMMIT MEDICAL ASSOCIATES, P.C., ET AL. V. FOB JAMES, JR., ET AL.*, 984 F.SUPP. 1404 AT 1420 (JAN. 26, 1998) IN RELATION TO *BILL PRYOR V. SUMMIT MEDICAL ASSOCIATES*, NO. 99-1041.

As noted by the Trial Court below in ***Summit Medical Associates, P.C., et al. v. Fob James, Jr., et al.***, supra, the **11TH Amendment** issue presents a case of first impression in the partial birth abortion area. Governor Fob James, Jr. and Attorney General Bill Pryor pleaded the **11TH Amendment** and the ***Younger*** **Abstention Doctrine** as a jurisdictional bar which precluded the Federal Court from asserting subject matter jurisdiction over the Plaintiff's Complaint as filed. The Motion of Amicus Curiae James J. Clancy, timely filed in ***Pryor***, supra,

on February 2, 2000, was made necessary because the issue of subject matter jurisdiction under the **11TH Amendment**, which was the paramount issue raised in the Court below and in the Court of Appeals, is not discussed in the Attorney General's Petition for Writ of Certiorari.

For the past 26 years, Amicus has been waiting for the day when a case such as ***Pryor v. Summit Medical Associates***, No. 99-1041, would reach this Court's Docket and force the issue as to whether the ***Younger v. Harris***, 401 U.S. 37 (1971) and ***Huffman v. Pursue, Ltd.***, 420 U.S. 592 (1975) and ***Watson v. Buck***, 313 U.S. 387 (1941) **Abstention Doctrines** are jurisdictional when an **11TH Amendment** challenge is raised by a state as a jurisdictional bar in the Federal Court and before trial.

CERTIORARI SHOULD BE GRANTED IN *BILL PRYOR V. SUMMIT MEDICAL ASSOCIATES*, NO. 99-1041 AND SET FOR ORAL ARGUMENT IN TANDEM WITH *STENBERG V. CARHART*.

Governor Fob James' Motion to Dismiss the Civil Rights complaint in ***Summit Medical Associates v. Fob James, Jr.***, supra, for lack of subject matter jurisdiction pursuant to the **11TH Amendment** has framed the **11TH Amendment** issue. The issue of Governor James' jurisdictional defense having been raised in Amicus James J. Clancy's Brief in ***Bill Pryor v. Summit Medical Associates***, No. 99-1041, this Court must now decide that jurisdictional issue in ***Pryor***, supra, at the outset, ***sua sponte***, in relation to the impact that the "bar" in ***Pryor***, supra, will have on ***Stenberg v. Carhart*** and on all of the Partial Birth Abortion cases on this Court's Docket this Term, and should, therefore, grant its writ of certiorari in ***Bill Pryor v. Summit Medical Associates*** now and set it for oral argument in tandem with ***Stenberg v. Carhart***.

Under Amicus' analysis of "subject matter jurisdiction", the definitive question in ***Bill Pryor v. Summit Medical Association***, No. 99-1041, under the **U.S. Constitution** and ***Steel Co.***, supra, is: "Is it a case of **11TH Amendment** (constitutional) subject matter jurisdiction for the state court to decide, or is it **Article 3,§2** (statutory) federal subject matter jurisdiction for the U.S. District Court to decide. The issue of "lack of subject matter jurisdiction" which is before the Federal Court in Governor Fob James, Jr.'s case, pursuant to the ***Younger - Huffman*** **Abstention Doctrines**, is adversarial, and is jurisdictional– jurisdiction is in either the State Court or it is in the Federal Court– it cannot be in both!

Nor has the **11TH Amendment** jurisdictional bar been "waived" where the facts demonstrate that the issue could and should have been raised by Arkansas and Nebraska. The failure to raise the issue, very definitely, was not a conscious waiver on the part of the State of Arkansas or Nebraska.

A decision in ***Bill Pryor v. Summit Medical Associates***, supra, that Governor James was correct and that his motion must be granted to allow the Alabama State Judiciary to perform its constitutional duties with respect to new legislation on behalf of the Sovereign State of Alabama will require that all of the other Partial Birth Abortion cases which will reach this Court's Docket, must be vacated in order that each of the States of Alabama, Nebraska, Illinois, Wisconsin, and the other States might have their State Courts render an initial State Court construction pursuant to ***Steel Co.***, supra, and the **11TH Amendment**.

Dated: **February 28, 2000**

Respectfully submitted,

James J. Clancy
Counsel of Record.

BRIEF OF AMICUS CURIAE JAMES J. CLANCY IN SUPPORT OF NEITHER PARTY.

INTRODUCTION

In 1998, the underlying rationale of ***Roe v. Wade***, 410 U.S. 113 (1973) was seriously eroded by two scientific events which took place in the form of: **(1)** a mishap which, only recently, has come to light; and **(2)** benefits in the form of an operation to cure the genetic disease of Spina Bifida which were bestowed upon an unborn "child-person" of 24 weeks while "partially" out of the womb.

In 1998, a scientific "mishap" occurred which recently, has been brought to the public's attention. As a result of this mishap, it has been revealed and established by irrefutable "living" proof that "an entire person" with a separate and distinct D.N.A. identification is "created" at the fertilization of the female embryos by the male sperm, and before the implantation in the womb of the female (see the analysis of Thomas F. Fee and other news articles of such "mishap" at **Appendix A** and **Appendix B** to this Amicus Brief).

One of the results of the second scientific event is to raise a question whether due process and equal protection of the law are being accorded unborn "child-persons", while in the womb of the female, and whether the female should be held responsible for its "care" while in the womb. See, in this regard, and compare the unequal protection of the laws of a community which confers a benefit upon a 24 week old unborn "child-person" in the form of an operation and cure, at the instance of an exceptionally qualified physician-surgeon for the genetic disease of Spina Bifida, while "partially" out of the womb, while at the same time tolerating the death and destruction by dismemberment of the body of a healthy unborn "child-person", also age 24 weeks by Abortionist Leroy Carhart while performing a "partial" birth abortion, as described by the U.S. District Court at **Appendix A-1** to this Amicus Brief. See the

news reports at **Appendix B** to this Amicus Brief and compare the same with the news account at **Appendix A**.

If one unborn, healthy "child-person" at age 24 weeks can be destroyed by being dismembered by Abortionist Carhart while "partially" out of the womb, for the mere convenience of the woman, while another unborn "child-person" at age 24 weeks with a birth defect is being saved (cured) through an extraordinary operation by an experienced surgeon at the expense of the community, can these two events be reconciled with the"due process", and "equal protection of the laws" concepts, and the oath of our forefathers when they signed the Declaration of Independence and swore to uphold the Laws of Nature and Nature's God ?

THE "GIST" OF THIS AMICUS CURIAE BRIEF.

Amicus Curiae respectfully submits that the ***Huffman*** **Abstention Doctrine** as it is presently being administered is wrong-headed. It was formulated as a jurisdictional rule to separate **Article 3, §2** jurisdiction (based upon the fiction that the state actor is a "rogue") from **11TH Amendment** jurisdiction, and should have been applied, as such, by the U.S. District Court. However, during the past 27 years this Court has never come together and admitted that background fact in any of the many opinions on the ***Younger*** - ***Huffman*** **Abstention** cases.

This Court can and should correct that defect in ***Bill Pryor v. Summit Medical Associates***, supra, by granting certiorari in that cases and ordering U.S. District Judge Myron H. Thompson to vacate his judgment in the trial court for lack of subject matter jurisdiction under the **11TH Amendment**, the ***Huffman*** **Abstention Doctrine** and its progeny: ***Middlesex Ethics Comm. v. Garden State Bar Assn.***, 457 U.S. 423 (1982), ***Migra v. Warren City School Dist. Bd. of Ed.***, 465 U.S. 75 (1984), ***University of Tennessee v. Elliott***, 478 U.S. 788 at 799 (1986), and ***Plough v. West Des Moines***

Community School District, 70 F.3d 512 at 516-517 (CA 8TH 1995); and under the ***Rooker-Feldman*** **Abstention Doctrine**, the **Res Judicata Doctrine** and the **Stare Decisis Doctrine** of this Court as set forth in the Amicus Curiae Brief of James J. Clancy, filed February 2, 2000, in ***Bill Pryor v. Summit Medical Associates***, No. 99-1041, and herein on February 28, 2000, in ***Stenberg v. Carhart***.

In his opinion, U.S. District Judge Myron H. Thompson erroneously assumed that the ***Younger*** **Abstention Doctrine** was not applicable because a case involving the Statute was not pending in the State Court. See ***Summit Medical Associates***, 984 F.Supp. 1404 at 1432-1433. Amicus contends that Judge Thompson's assumption is fatal to his judgment for the Plaintiffs. The **11TH Amendment**, which is the foundation for and "factored" into ***Younger - Huffman*** **Abstention**, is a broader and more fundamental doctrine. See ***Pennzoil Co. v. Texaco, Inc.***, 481 U.S. 1 at 14-17 (1987) at fn. 9 on page 16:

> "9. In some cases, the probability that any federal adjudication would be effectively advisory is so great that this concern alone is sufficiently to justify abstention, even if there are no pending state proceedings in which the question could be raised. See ***Railroad Comm'n of Texas v. Pullman Co.***, 312 U.S. 496, 85 L.Ed.2d 971, 61 S.Ct. 643 (1941)." (My emphasis.)

Bill Pryor v. Summit Medical Associates, supra, is "such a case". The Legislation therein involves an "as applied" constitutional claim. The Trial Court's "referral of questions" to the Alabama Supreme Court and that Court's refusal to reply makes the Federal Court's Opinion merely "advisory" and satisfies the requirement of ***Pennzoil Co. v. Texaco, Inc.***, supra, and the **11TH Amendment**.

In the trial of the Alabama Partial Birth Abortion case, ***Summit Medical Associates, et al.*** cannot reinterpret ***Ex Parte***

Young, supra, or use it to overrule ***Younger***, supra, because ***Ex Parte Young*** was "factored" into Justice Hugo Black's majority opinion in ***Younger***. The Federal District Court is bound by ***Younger*** and ***Huffman***, supra, and is required to make the special jurisdictional findings which ***Younger*** requires. See ***Huffman***, 420 U.S. at 611-613 and **page 3** of the Motion for Leave to file an Amicus Curiae Brief. That jurisdictional burden was on the Federal Plaintiff who had to plead and prove his right to be in the Federal Court. None of the Plaintiffs in any of the Partial Birth Abortion cases on file in this Court has satisfied its burden.

The ***Younger*** **Abstention Doctrine** is controlling even where there is no state case pending at the time of filing the federal action where, as here, the State Court has not had an opportunity to interpret the State Statute, and such an interpretation can "save" the Statute– the so-called ***Watson v. Buck***, supra, exception which is referred to and "factored into" Justice Black's opinion in ***Younger v. Harris***, 401 U.S. 37 at 45-46 and 49.

In his analysis, Judge Thompson did not consider the ***Younger - Huffman*** **Abstention Doctrines** as an integral part of the **11TH Amendment** challenge. See ***Summit Medical Associates***, supra, 984 F.Supp at 1419:

> "IV. ATTORNEY GENERAL DEFENDANTS' JURISDICTIONAL CHALLENGES
>
> " . . . .
>
> " For the sake of clarity, and to ensure that it fully and properly resolves each of the attorney general defendants' challenges, the court will address them separately and systematically. First, it will determine whether, as the attorney general defendants contend, all of the plaintiffs' claims are barred by the eleventh amendment, so that the entire lawsuit must be dismissed.

> Next, the court will ascertain whether the suit as a whole, or any subset of the plaintiffs' claims, must be dismissed for lack of an Article III case or controversy. To resolve this issue, the court will address whether the plaintiffs enjoy standing to bring their various claims, as well as whether any of these claims has been rendered moot, and hence non-justiciable, in light of the defendants' post-filing actions. Finally, the court will determine whether any of the abstention doctrines, grounded on considerations of comity between the state and federal judicial systems, and on principles that govern federal [**19] courts sitting in equity, counsels dismissal of any of the plaintiffs' claims, or a stay pending resolution by the Alabama Supreme Court of any issues raised by these claims. . . . . " (My emphasis.)

The U.S. District Judge's analysis of the Alabama Attorney General's Jurisdictional challenges which appears thereafter at pages 1420-1439 reads:

> "A. **11TH Amendment**, 984 F.Supp. 1404 at 1420-1425.
> "B. **Article III** Case or Controversy requirements, 1425-1432.
> 1. Standing, 1425-1430.
> 2. Mootness, 1430-1432.
> "C. **Abstention Doctrines**, 1432-1439.
> 1. ***Younger*** **Abstention**, 1432-1434.
> 2. **Equity Principles**, 1434-1436.
> 3. **Pullman Abstention**, 1436-1439."

As can be seen from the above outline, the ***Younger*** **Abstention Doctrine**, which should be analyzed at "Point A" on page 1420 (at the very beginning) because it and the ***Huffman*** **Abstention Doctrine** are squarely on point and controlling, appears, as an afterthought, as one of the General Abstention Doctrines to be considered as a mere matter of Equity.

THE IMPORTANCE OF *STENBERG V. CARHART*, NO. 99-830.

As to ***Stenberg v. Carhart***, the review exercised by the 8TH Circuit Court of Appeals below must be regarded as being merely "advisory", as a matter of law. It very clearly does not meet the "Standard of Review" which the Nebraska Judiciary has established as a part of the Public Policy of the Sovereign State of Nebraska. See ***Nebraska v. Divis***, 256 Neb. 328, 589 N.W.2d 537 (1999), "Standard of Review", reading at 256 Neb., page 330:

> Whether a statute is constitutional is a question of law, with respect to which an appellate court has an obligation to reach a conclusion independent of that of the trial court. State v. Torres, 254 Neb. 91, 574 N.W.2d 153 (1998); State v. Roucka, 253 Neb. 885, 573 N.W.2d 417 (1998). The party challenging the constitutionality of a statute bears the burden to ' "clearly establish[ ]' " the unconstitutionality of a statutory provision. State v. Schmailzl, 243 Neb. 734, 736, 502 N.W.2d 463, 465 (1993), quoting Weiner v. State ex rel. Real Estate Comm., 217 Neb. 372, 348 N.W.2d 879 (1984). Statutes are presumed to be constitutional, and all reasonable doubts will be resolved in favor of constitutionality. State v. Philipps, 246 Neb. 610, 521 N.W.2d 913 (1994). A penal statute must be construed so as to meet constitutional requirements, if such a construction can be reasonably accomplished. State v. Bainbridge, 249 Neb. 260, 543 N.W.2d 154 (1996)." (Our emphasis.)

and at page 331:

> " For a claim of unconstitutionality based on the face of a statute to succeed, the party challenging the statute must show that the law impinges on some fundamental constitutional right or that the law creates a suspect classification. Robotham v. State, 241 Neb. 379, 488 N.W.2d 533 (1992).
>
> > 'If the . . . Law implicates neither fundamental rights nor suspect classifications, it must be upheld unless it bears no rational relationship to a legitimate government interest.'
>
> "Id. at 383, 488 N.W.2d at 538. See, also, United States v. Salerno, 481 U.S. 739, 107 S.Ct. 2095, 95 L.Ed.2d 697 (1987) (holding that facial challenge to legislative act is most difficult challenge to mount successfully, because challenger must establish that no set of circumstances exists under which act would be valid)." (Our emphasis.)

and at page 332:

> " The separation of powers clause is contained in Neb. Const. Art. II, §1. It provides:
>
> > 'The powers of the government of this state are divided into three distinct departments, the legislative, executive and judicial, and no person or collection of persons being one of these departments, shall exercise any power properly belonging to either of the others, except as hereinafter expressly directed or permitted.'
>
> " We have observed that the separation of powers clause
>
> > 'prohibits one department of government from encroaching on the duties and prerogatives of the others or from improperly delegating its own duties and prerogatives, except as the Constitution itself otherwise directs or permits.'

"State v. Philipps, 246 Neb. 610, 614, 521 N.W.2d 913, 916 (1994). See Otey v. State, 240 Neb. 813, 485 N.W.2d 153 (1992)." (Our emphasis.)

and at page 334:

" Similarly, the Legislature has the authority to fix the penalty range with can be imposed for the crimes it has defined. The Legislature determines the nature of the penalty imposed, and so long as that determination is consistent with the Constitution, it will not be disturbed by the courts on review. In this regard, in State v. Tucker, 183 Neb. 577, 579, 162 N.W.2d 774, 776 (1968), quoting State ex rel. Nelson v. Smith, 114 Neb. 653, 209 N.W. 328 (1926), we observed:

' "The legislature is clothed with the power of defining crimes and misdemeanors and fixing their punishment; and its discretion in this respect, exercised within constitutional limits, is not subject to review by the courts." '

"See State v. Tatreau, 176 Neb. 381, 126 N.W.2d 157 (1964)."

and at page 335:

" It is the role of the court, to the extent possible, to give effect to the entire language of the statue, and to reconcile different provisions of the statute, 'so they are consistent, harmonious, and sensible.' Van Patten v. City of Omaha, 167 Neb. 741, 751, 94 N.W.2d 664, 670 (1959). When considering a statute's meaning, it is appropriate for the court to consider

'the evil and mischief attempted to be remedies, the objects sought to be accomplished, the scope of the remedy [to which] its terms apply, and

[to] give [the statute] such an interpretation as appears best calculated to effectuate the design of the . . . legislative provisions'

"E.K. Buck Retail Stores v. Harkert, 157 Neb. 867, 872-73, 62 N.W.2d 288, 294 (1954)." (Our emphasis.)

CONTENTIONS OF AMICUS CURIAE JAMES J. CLANCY.

Younger v. Harris, supra (1971), was a 5-4 decision. The majority opinion, which was written by Justice Hugo Black, clearly rejected the type of interference which was employed by the Federal Court in this case. Although Justice Black was an absolutist on the **1ST Amendment**, he was a stronger supporter of "State's Rights" under the **11TH Amendment**, which is reflected in his ***Younger*** opinion, which involved a prosecution involving free speech. His "***Younger***" opinion (the ***Younger*** **Abstention Doctrine**) "reconciled" the principles expressed in 5 cases: ***Ex Parte Young***, 209 U.S. 123 (1908): ***Younger*** at 45; ***Dombrowski v. Pfister***, 380 U.S. 479 (1965): ***Younger*** at 48; ***Watson v. Buck***, 313 U.S. 387 (1941): ***Younger*** at 46, 49, 53; ***Fenner v. Boykin***, 271 U.S. 240 (1926): ***Younger*** at 45-46; ***Atlantic Coast Line R. Co. v. Engineers***, 398 U.S. 281 (1970): ***Younger*** at 40. The ***Younger*** **Abstention Doctrine** is firmly grounded upon the Sovereign right of each state under the **10TH and 11TH Amendment** to have its important state interests (both criminal and civil) tried and decided by the State Judiciary, which has the absolute right to "interpret" the statute and "assist" the State Legislature in its effort to write constitutional legislation, where possible, see ***Watson v. Buck***, supra. See, in this regard, the public policy expressed by the Nebraska Supreme Court in ***Nebraska v. Divis***, supra, at **pages 6-9** of this Amicus Brief.

Summit Medical Associates' race to the courtroom in No. 99-1041 was fatal to its cause. By filing its Complaint in July, two weeks before the Statutes became effective (on

August 1ST and 12TH, 1997), it is unable to establish that the U.S. District Court had federal subject matter jurisdiction at the time the Complaint was filed because the statutes did not exist in July and were not effective. See, also, ***Hicks v. Miranda***, 422 U.S. 332 (1975) which would have been available to the Alabama Attorney General had he elected to use it (i.e., by filing a declaratory judgment action in the State Court alleging all of the issues raised by Summit and moving to dismiss the Federal action on the grounds that he was not acting as a "rogue"; and, under the **11TH Amendment**, the first interpretive decision of the Statute must be by the Alabama Supreme Court after the first trial under the Statute except where the ***Younger*** special findings of fact exist).

I INTEREST OF AMICUS CURIAE: BACKGROUND.

Amicus learned of the Alabama Attorney General's **11TH Amendment** challenge to Federal jurisdiction and the 11TH Circuit's Opinion in ***Summit Medical Associates, P.C.; et al. v. Pryor, et al.*** No. 98-6129 (July 15, 1999) from a subscription copy of **68 U.S.L.W.** at **1079**, dated August 10, 1999 and requested his computer operator to obtain a copy from the Internet.

On August 18, 1999, Amicus received a copy of the opinion from the (BNA) Internet and made four phone calls to the Attorney General's Office in Montgomery, Alabama (334-242-7300). Upon inquiry, he was informed that Bert Jordan in Birmingham was one of the attorneys for Attorney General Pryor on appeal.

On September 2, 3, 10, 11 and 14, 1999, Amicus phoned Bert Jordan (205-870-0555). On September 14TH Amicus had a lengthy (44 minute) phone conversation with Jordan in which the importance of the Alabama Attorney General's **11TH Amendment** challenge as a case of first impression was discussed at great length. Jordan informed Amicus that he was

one of the attorneys on the case, and that a petition for rehearing en banc would be filed.

On October 18, 1999, Amicus had a second lengthy (43 minute) phone conversation with Jordan and was informed that a petition for rehearing would be filed on or about November 10, 1999 and that the matter of filing a petition for certiorari was being discussed, but it was not known who would prepare the petition.

During the above two lengthy phone conversations with Jordan, Amicus expressed his interest in the Alabama Attorney General's Petition for Certiorari and his convictions: **(1)** that the ***Summit*** case should be reversed upon the authority of ***Younger v. Harris***, supra, and ***Huffman v. Pursue, Ltd.***, supra, because they were squarely in point on the **11TH Amendment** issue and were controlling; and **(2)** that Amicus had been attempting to raise that issue in the U.S. Supreme Court since 1975 (25 years); and was presently trying to do so in a case known as ***In Re Clarence Murphy***, No. 98-1442, etc.; and also explained most of the contentions of Amicus regarding his reason why the ***Younger*** and ***Huffman*** **Abstention Doctrines** were controlling.

On Saturday, January 15, 2000, Amicus learned from an ***L.A. Times*** news article that this Court had granted a Writ of Certiorari in ***Stenberg v. Carhart***, No. 99-830. On Monday, January 24, 2000, Amicus was informed by the Alabama Attorney General in Montgomery (334-242-7445 [Michael Jackson]) that Attorney Jay Sekulow in Washington, D.C. was preparing the Petition for the Alabama Attorney General. On January 27, 2000, Amicus received a fax copy of the Petition from Attorney Sekulow and learned for the first time that neither the **11TH Amendment** issue nor the ***Younger*** **Abstention Doctrine** issue was raised in the Petition for Writ of Certiorari even though the **11TH Amendment** issue was the principal issue urged by the Attorney General in the Trial Court. On January 28, 2000, Amicus faxed a request for consent to

filing an Amicus Curiae Brief for the benefit of the Court on the **11TH Amendment** and the ***Younger*** - ***Huffman*** **Abstention** issues so that those issues could be argued.

On February 1, 2000, Simon Heller refused to consent in writing as attorney for ***Summit Medical Associates***. Walter Weber has not yet responded in writing for Petitioner ***Bill Pryor***. On February 2, 2000, the Clerk of this Court timely filed the Amicus Curiae Brief of James J. Clancy in Case No. 99-1041, which addressed the Subject Matter Jurisdiction Issue which was inadvertently omitted from the Alabama Attorney General's Petition.

II INTEREST OF THE AMICUS CURIAE: A RE-EXAMINATION OF *HUFFMAN V. PURSUE, LTD.*, 420 U.S. 592 (1975) IS CONTRAINDICATED.

27 years ago (May 1973), the substantial federal question which controls this case; namely, the conflict that necessarily occurs between the subject matter jurisdiction of federal courts under the **14TH Amendment (42 U.S.C. §1983)** and **Article 3, §2** of the **U.S. Constitution**; and the subject matter jurisdiction of state courts under the **10TH and 11TH Amendments** to the **U.S. Constitution**, was squarely before this Court in two forms: **(1)** in ***Lawrence S. Huffman v. U.S. District Court for the Northern District of Ohio, Western Division***, No. 72-1613 Misc., being a Motion for Leave to file a Petition for Writ of Mandamus and Petition for a Writ of Mandamus as to this Court's original jurisdiction pursuant to **28 U.S.C. 1651(a)**; and **(2)** in ***Lawrence S. Huffman v. Pursue, Ltd.***, No. 73-296, which is now reported as 420 U.S. 592, supra, being an appeal from an adverse judgment of a three judge court with respect to the constitutionality of the Ohio Public Nuisance Statute as applied in the Lima, Ohio Public Nuisance Abatement action as then required by this Court's mandatory appellate jurisdiction under **28 U.S.C. §2281** (repealed in 1976).

Amicus Curiae James J. Clancy [V] was Counsel of Record for Allen County, Ohio Prosecutor Huffman (hereinafter "Huffman") in Huffman's two cases in 1975. A duplicate copy of the Jurisdictional Statement and the Petition for Rehearing in ***Huffman v. Pursue, Ltd.***, No. 73-296 and the Motion for Leave to File a Petition for Writ of Mandamus and Petition for Writ of Mandamus in ***Huffman v. U.S. District Court***, No. 72-1613 Misc. was filed with this Court as "Exhibits 1A, 1B and 1C" to the Petition for Writ of Mandamus in ***In Re Murphy***, No. 98-1442, with a request that this Court take Judicial Notice of such pleadings.

II (A) The Critical Status of the Ohio State Court's Jurisdiction and Huffman's Dilemma.

The final judgment which closed the Cinema I Theater in Lima, Ohio as a Moral Public Nuisance in the Ohio public nuisance case was filed on November 30, 1972. The attorneys for the theater transferred the ownership to a newly formed Corporation and on the next day (December 1, 1972) filed a civil rights action in the U.S. District Court attacking the constitutionality of the Ohio Public Nuisance Statutes (which required Appellate review by a three judge federal court).

On December 1, 1972, the date the action was filed (which is the date upon which the subject matter jurisdiction of the federal court is routinely tested and determined), the Common Pleas Court in Lima Ohio still had statutory jurisdiction for 30 days for the purpose of considering post trial motions, the filing of a notice of appeal and motions for attorneys' fees, etc.

In the two ***Huffman*** cases which were before this Court,

V Amicus Curiae James J. Clancy also was and is counsel of Record for Clarence F. Murphy in his Petition for Writ of Mandamus in ***In Re Murphy***, U.S. Supreme Court No. 98-1442, October Term 1998. See **Point III**, infra, at **pages 18-24**, and see **Appendix C** to this Amicus Brief.

Huffman made a determined effort to focus the Court's attention on Lack of "Subject Matter Jurisdiction" which, according to this Court's prior precedents was and is always to be the first order of business (see ***Steel Co. v. Citizens for a Better Environment***, 523 U.S. 83 [March 4, 1998]) and properly belonged in the Ohio State Court System. This tactic was absolutely essential to the prosecutor's success, so that he could stop the federal interference and get a definitive appellate ruling on the "closure" procedure by the Ohio Supreme Court in this ***Huffman*** "test case" (which ruling would also be available as "precedent" in other State Public Nuisance Abatement cases [see **Appendix D** to this Amicus Brief at pages **D-8** through **D-11**] which were then being developed using the civil abatement process, and the Time and Motion Study and Film Continuity Study as real evidence for the prosecution, and the potential of an award of attorney's fees to cover the cost of abatement and closure of the Ohio Moral Public Nuisance).

II (B) Abdication of this Court's Primary Duty re Jurisdiction in *Huffman*– Ohio's Concern re Moral Depravity, an Important State Interest under the 10TH and 11TH Amendments.

Unfortunately, this Court, as in ***Cooper v. Mitchell Brothers' Santa Ana Theater***, infra, at **pages 24-25** to this Amicus Brief, avoided answering the lack of "subject matter jurisdiction" question which was squarely raised in the (original) Petition for Leave of Court to File a Petition for Writ of Mandamus after Solicitor General Robert Bork informed the Court that the "Jurisdictional Statement" on the mandatory appeal had been filed in the interim and that the "jurisdiction" question "could" (not "would") be addressed in that case when this Court heard that appeal pursuant to its mandatory appellate jurisdiction of the three Judge Court Judgment.

In 1973, the National need for a decision and an extraordinary writ upholding the subject matter jurisdiction of a state court on important state matters such as the abatement

of moral public nuisances pursuant to **Chapter 3767** of the **Ohio Revised Codes** and the **10TH and 11TH Amendments** was abundantly clear. The "moral depravity" which then was being exhibited by the escalating pornography industry and porn industry films, such as the film "Deep Throat", (which "glorified" sodomy per o.s. [oral sodomy]) were appearing as the regular fare at the Cinema I Theater in Lima, Ohio and on motion picture screens in each of the 50 States. The federal courts were wrongfully being employed by the porno industry to interfere with the **10TH and 11TH Amendment** efforts of law enforcement to produce real evidence of such hard-core films in the state courtrooms using: **(1)** the search warrant process; and **(2)** the subpoena duces tecum process. See, for example, ***Hicks v. Miranda***, 422 U.S. 322 (1975) as an example of the intrusive litigation faced by law enforcement.

In May of 1973, the depravity that files like "Deep Throat" represented in its graphic depictions of "oral sodomy" (o.s.) was uniformly recognized as being contrary to the "Natural Law" and Judaeo Christian moral standards, and acknowledged as such by an overwhelming majority of the legal profession. 23 years earlier (1950), Professor Rollin M. Perkins, now Connell Professor of Law Emeritus, U.C.L.A. Professor Emeritus, University of Hastings College of Law had instructed Amicus Curiae herein (as a first year law student in Prof. Perkins' criminal law class at U.C.L.A.), and later published in his definitive text on the Criminal Law, that the Common Law in the United States with respect to this subject (oral sodomy) and "public morals" was clearly defined and well documented. [2]

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[2] See text of ***Perkins*** on **Criminal Law** (at pages 465-466), *the Foundation Law Press*, 3RD Ed., (first published in 1955), which reads in part:

> " The ancient city of Sodom, reputedly destroyed because of its unspeakable vices, is the source from which the word 'sodomy' is derived. The offense was regarded with such abhorrence in the early days that Blackstone literally refused to name it, referring to it only as 'the infamous *crime against*

II (C) The Prosecuting Attorney's Interests Versus This Court's Interests in *Huffman*.

In both cases, Huffman asked that the U.S. District Court Order be vacated and that the case be remanded to the Ohio Judicial System (so that a final appellate decision could be achieved).

The "Questions Presented" at pages 5-9 and the "Statement of Facts" at pages 9-28 of the Petition for Writ of Mandamus in No. 72-1613 Misc. was purposely comprehensive [2] and tailored to the Prosecutor's special needs so that anyone in the appellate chain who later undertook a study of those documents would immediately recognize the validity of the jurisdictional issue being raised and the need for an issuance of a **Rule *Nisi*** re jurisdiction.

This Court was thinking of the Federal Judiciary's own National needs, and was not (primarily) interested in the practical aspects of the Public Nuisance Abatement case in relation to the "real" needs of the State of Ohio.

At Oral Argument, Justice Stewart asked if Ohio would be satisfied if the ***Younger* Rule** in criminal cases were extended to civil proceedings. Prosecutor Huffman answered "No", in that, under this Court's own precedents, it must first address the question of "subject matter jurisdiction"– i.e., whether the case was properly before the Court– realizing that the State of Ohio had a very real need for its presence in the State of Ohio and an Ohio Appellate Ruling by the Ohio Supreme Court, and the U.S.

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nature.' [25] 4 Bl.Comm. *215. " (Our Emphasis.)

[2] See, in particular, at "Appendix C", pages C-7 through C-10, the pleading by reference of the time/motion studies of the films named, at paragraph 7(j) and 10(c) of the Complaint to abate the Cinema I Theater as a public nuisance.

District Court had interfered with the **11TH Amendment** subject matter jurisdiction of the State of Ohio Judicial System, as to an important State Interest which could and should be addressed in the State Court.

Amicus Curiae James J. Clancy recalls that, during oral argument, with knowledge of what was happening in "society" (in the "real world", the State Courts were being ham-strung by "technical" procedural decisions in their attempts to introduce the "prints" of hard-core pornographic films like "Deep Throat" in evidence before the State Courts on the merits) he stated, as his opinion, that the federal courts' ruling in the ***Huffman*** case was underwriting "cocksucking and whore mongering"– language never before used by Amicus Curiae in his professional career, or in conversation. Amicus Curiae had determined that he would "sound" this "warning prediction" to the Court if such a statement became necessary. It was necessary, but proved to be ineffective. A majority of the Court was determined to extend the ***Younger* Rule** to civil cases, and would say or do no more.

Unfortunately, the fractured nature of the Court in 1975 prevented the Justices from coming together on the **11TH Amendment** issue. Instead of remanding the case to the Ohio Judicial System for further proceedings, the majority of Justices complied with their duty by addressing the jurisdictional issue obliquely in a technical sense and formulated the **"*Huffman* Abstention Doctrine"** (as a proper response to the legal profession pursuant to the rudimentary rule of law that this Court always has jurisdiction to determine jurisdiction). Proof of the correctness of this "jurisdictional" analysis can be found in the last paragraph of the Court's Opinion in ***Huffman v. Pursue, Ltd.***, supra, (see **page 3** of the Motion for Leave to file an Amicus Curiae Brief).

II (D) The Battle was Won, but the "War" was Lost. This Court Can, and must Correct That Defect.

That Huffman had prevailed on his appeal was no great victory. The "battle" was won, but the entire war against such obscene hard-core pornography was lost. Huffman acknowledged that reality by filing a Petition for Rehearing, which was summarily denied. The case was not remanded back to the Ohio Appellate Courts for their consideration, as requested by the State of Ohio in its Appeal, and the "closure" issue which was then before this Court was never resolved. ***Pursue, Ltd.***, the Plaintiff in the Federal District Court, refused to litigate further and disappeared. [4]

III. INTEREST OF THE AMICUS CURIAE: STATEMENT OF THE CASE OF CLIENT CLARENCE F. MURPHY, IN THE U.S. SUPREME COURT IN CASE NO. 98-1442.

In Case No. 98-1442, Planned Parenthood wishes to construct and operate an abortion clinic in Bettendorf, Iowa. [5]

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[4] See **Appendix D** to this Amicus Curiae Brief, being a contemporary historical account recently prepared by Amicus Curiae, writing of the disaster which resulted from the inability of law enforcement and the denial of the states' right under the **10TH** and **11TH Amendments** to obtain a resolution of the "closure" issue in the ***Huffman*** case, supra, and other state cases in which the Federal District Court wrongfully interfered with the State Court's pending action. See, also, the discussion as to the two ***Spokane Arcades, Inc.***, cases, infra, which were before this Court, as discussed hereinafter at **pages 25-29** to this Amicus Brief.

[5] Because this Court has refused to exercise its discretion and act upon Murphy's petitions and motions for relief from this Court, Planned Parenthood has been able to construct a Clinic. Planned Parenthood has not yet, however, been able to establish the right to operate an abortion clinic within 100 feet of Murphy's residential apartments under Iowa Law or the right of the U.S. District Judge Wolle to rezone the property from P.U.D. to C-5. See **Appendix C** to this Amicus Curiae Brief.

The **Bettendorf Zoning Ordinance** allows abortion clinics on property in a C-5 Zone.

Had Planned Parenthood purchased a C-5 Zoned property, it would not have had a zoning problem. Instead, it chose a property in a PUD Zone within 200 feet of three relatively new residential apartment complexes and submitted an application for approval of a C-5 Zoning Ordinance.

Murphy and two other adjacent apartment owners within 200 feet of the Planned Parenthood property made a successful statutory protest (**20% Rule**) against the zone change, pursuant to **Bettendorf Zoning Code, §24.2 and §24.4** (see at **Appendix C** to this Amicus Brief, Murphy's Iowa District Court Petition for a Declaratory Judgment filed on December 7, 1999 as a means of attacking and solving U.S. District Judge Wolle's refusal to allow Murphy to litigate Judge Wolle's egregious rulings in the Federal Court), which precluded the Bettendorf City Council from adopting a C-5 Zoning Ordinance unless the City Council voted 6-1 in favor of the Zoning Ordinance. The City Council aligned itself with the protesters and on March 19, 1996 voted 5-1 to reject the C-5 Zoning Ordinance. That quasi-judicial order was not appealed and is now final and ***Res Judicata*** under Iowa Law.

Zoning Rights are "**Vested Rights**" under Iowa Law and the **Iowa Constitution**. The **8TH** Circuit Court of Appeals has so held in its decision in ***Nemmers v. City of Dubuque, Iowa***, 716 F.2d 1194 (1983).

Under Iowa case law, a city council's action on a zone change request is broadly defined to be a "judicial function" which can be appealed by writ of certiorari to the Iowa District Courts, see ***Montgomery v. Bremer County Board of Supervisors***, 299 N.W.2d 687 at 692 (Iowa Supreme Court 1980). If an appeal is not filed within 30 days, the city council's actions become final, in which case, under the **11TH Amendment** and ***Huffman v. Pursue Ltd.***, 420 U.S. 592

at 606, fn. 18 and 19 and the progeny of ***Huffman***, and ***Plough v. West Des Moines Community School District***, 70 F.3d 512 at 516-517 [CA 8TH 1995]), the city council's quasi-judicial order is both final and ***Res Judicata*** under the U.S. Supreme Court decisions.

On March 21, 1997, one year and two days after the City Council's rejection of the C-5 Zoning Ordinance, Planned Parenthood filed a Civil Rights Action under **42 U.S.C. §1983** in the U.S. District Court, pleading what is, in essence, an appeal from the March 19, 1996 decision of the Bettendorf City Council which considered essentially the same issues and facts and denied the application for the C-5 Zoning Ordinance in a quasi-judicial order which was not appealed to the Iowa District Court. The federal complaint: **(1)** did not name the three adjacent apartment owners who made the successful statutory protest as defendants; and **(2)** demanded attorney's fees under **42 U.S.C. §1988**.

The City of Bettendorf filed a Summary Judgment Motion, pursuant to the ***Huffman*** **Abstention Doctrine** and the ***Res Judicata*** **Doctrine** which Judge Wolle egregiously denied.

Upon conclusion of the federal trial, Judge Wolle entered a judgment which purported to rezone the property from P.U.D. to C-5 Zoning and awarded very substantial attorney's fees to Planned Parenthood under **42 U.S.C. §1988** which would not have been available under Iowa Law had an appeal been taken to the Iowa District Court following the denial of the C-5 Zoning Ordinance.

Murphy moved to intervene in the U.S. District Court immediately after the City of Bettendorf ("***parens patriae***") announced its decision not to appeal, for the purpose of appealing U.S. District Judge Wolle's Judgement on **11TH Amendment**, the ***Huffman*** **Abstention Doctrine** and other jurisdictional grounds, including Judge Wolle's denial of the City's Summary Judgment Motion on its plea of ***Res***

Judicata.

Judge Wolle: **(1)** cited one case authority (the "cited" case actually upheld the mandatory right of Murphy to intervene) and ruled "cursorily" on Murphy's "extensive" pleadings that the Intervention Motion was "untimely"; **(2)** refused to address the merits of Murphy's right to mandatory intervention (or the "reasoning" behind the Court's "cited" authority); and the **11TH Amendment**; ***Res Judicata***, and other Jurisdictional claims raised at the time of Murphy's Intervention Motion, and **(3)** refused to hear oral argument on the intervention and jurisdictional claims.

In the Court of Appeals below, Murphy sought judicial relief from Judge Wolle's arrogation of Federal Judicial Power in two forms: by the filing of a direct appeal and the filing of an original action (a verified complaint pursuant to a Petition for Writ of Mandamus) in the 8TH Circuit Court of Appeals, pursuant to **28 U.S.C. §1651(a)**.

In a highly unorthodox ruling, which is totally inconsistent with Federal Practice, the 8TH Circuit Court of Appeals treated Appellant Murphy's Opening Brief on the direct appeal and the original petition for a prerogative writ of mandamus, as though they had been consolidated and, in a brief single order, summarily denied the petition for Writ of Mandamus without an opinion, and summarily affirmed Judge Wolle's Judgment, also without opinion. The 8TH Circuit Court of Appeals also denied a petition for rehearing and suggestion of a hearing en banc in each of the two cases.

Murphy contended in his Petition for Writ of Mandamus, pursuant to the U.S. Supreme Court's original jurisdiction: **(1)** that Planned Parenthood has not stated, and cannot state a **42 U.S.C. §1983** cause of action because it had an adequate remedy under Iowa procedure of judicial review by the Iowa District Court (see ***Allen v. McCurry***, 449 U.S. 90 at 100 [1980] and ***Parratt v. Taylor***, 451 U.S. 527 [1981]), and

(2) that it is not entitled to attorney's fees under **42 U.S.C. §1988** because Iowa and other state courts do not customarily award attorney's fees in litigation involving an appeal from a denial of a C-5 zoning ordinance and application of the **Bettendorf "Protest" Ordinance**; and **(3)** where, as here, a separate **42 U.S.C. §1983** cause of action is pleaded and relied upon, it must be tried in the Iowa District Court because of the **11TH Amendment** bar, and ***Res Judicata*** defense which has been pleaded; and **(4)** in any event, Judge Wolle's Judgment must be reversed because, at this state of the proceedings, the **11TH Amendment**, the ***Huffman*** **Abstention Doctrine** and the **Doctrines** of ***Res Judicata*** and ***Stare Decisis*** control the disposition of this case and mandate that the Federal Judgment must be vacated for lack of **Article 3, §2** subject matter jurisdiction.

Murphy contended he is entitled to a **Rule *Nisi*** pursuant to **28 U.S.C. §1651(a)** correcting the egregious refusal of both Courts to address the issue of "lack of **Article 3, §2** subject matter jurisdiction" under his **11TH Amendment** claim. See ***Steel Co. v. Citizens for a Better Environment***, 523 U.S. 83 (March 4, 1998) (duty to address the question of subject matter jurisdiction as the first order of business, and on its own motion, if the parties to the lawsuit do not bring the matter to the trial court's attention); ***Puerto Rico Aqueduct and Sewer Authority v. Metcalf & Eddy, Inc.***, 121 L.Ed.2d 605 at 610, 506 U.S. 139 (1993) (creating a new Rule of Court re the issue "lack of subject matter jurisdiction"); ***Wisconsin Dept. of Corrections v. Schacht***, 524 U.S. ___, 141 L.Ed.2d 364 at 375-378, No. 97-461 (June 22, 1998) (Associate Justice Kennedy's concurring opinion re the issue of "lack of subject matter jurisdiction"). See ***Kerr v. U.S. Dist. Ct.***, 426 U.S. 394 (1976); ***Will v. U.S.***, 389 U.S. 90 (1967); and **Supreme Court Practice**, *7TH Ed.*, ***Stern, Gressman, Shapiro, Geller*, ©1993** at page 495.

III (A) Adequate Relief Cannot Be Obtained by Murphy in Any Other Forum or from Any Other Court for the Following Reasons:

"Adequate Relief" in the above context means "giving notice to the U.S. District Courts and the U.S. Courts of Appeals in the 11 Circuits, that the ***Huffman*** **Abstention Doctrine** is "Jurisdictional" and that the Planned Parenthood Civil Rights Action must be dismissed on those grounds where the ***Huffman*** test has not and cannot be met. This requires a reexamination of this Court's opinion and decision in ***Huffman v. Pursue, Ltd.***, supra.

III (B) The Refusal of a Majority of Federal Courts to Acknowledge the "Jurisdictional" Aspect of the *Huffman* Abstention Doctrine in Such a Situation, Where Each Party Claiming Jurisdiction in a Different Entity, Manifests a Need for Re-Examination of the *Huffman* Cases.

Murphy contends that the rule of law re lack of **Article 3, §2** subject matter jurisdiction under this Court's opinion in ***Huffman v. Pursue, Ltd.***, supra, has existed for the past 24 years as an **11TH Amendment** right; yet few of the federal courts consider themselves bound thereby. See in this regard, U.S. District Judge Myron H. Thompson's analysis at **pages 3-5,** infra, to this Amicus Brief.

When faced with Murphy's lawful right to intervene as an indispensable party and to contest the U.S. District Court's actions (requiring the construction of an abortion clinic within 200 feet of his apartment complex) pursuant to Murphy's claim of lack of **Article 3, §2** subject matter jurisdiction under the **11TH Amendment**, the ***Huffman*** **Abstention Doctrine**, the ***Rooker-Feldman*** **Abstention Doctrine**, (***Rooker v. Fidelity Trust Co.***, 263 U.S. 413 [1923] and ***Dist. of Columbia Court of Appeals v. Feldman***, 460 U.S. 462 [1983]), the ***Res Judicata*** **Doctrine** and the ***Stare Decisis*** **Doctrine**, both the

U.S. District Court and the U.S. Court of Appeals for the 8TH Circuit dismissed such claims without an explanatory judicial opinion, in utter disregard of this Court's repeated admonitions that a federal court must rule on the jurisdictional issue as its first order of business.

Murphy submits that, in the light of what is said above about the background of the rule of law expressed in ***Huffman v. Pursue, Ltd.***, supra, and the great harm which has resulted from this Court's having refused to "squarely" address the **11TH Amendment** jurisdictional aspect of the ***Huffman*** case, this Court should clarify the rule of law on "lack of **Article 3, §2** subject matter jurisdiction" in ***Huffman***.

CONCLUSION

The Refusal of The Federal Courts of Appeal to Recognize And Treat The Right of The State Judiciary to Interpret New Legislation Under *Watson v. Buck* Abstention as an 11TH Amendment Right Involving Important State Interests And State Public Policy Has Had a Devastating Effect on Law Enforcement in The Public Morals Area And Needs to Be Corrected (See Appendix D to This Amicus) And in a Forceful Manner by Vacating the Judgments and Sending All of The Partial Birth Abortion Cases Which Are on Its Docket Back to The State Courts For Their Initial Interpretation And Construction.

On November 30, 1981, this Court handed down its 6-3 decision in ***(California ex rel.) Cooper v. Mitchell Brothers' Santa Ana Theater, etc., et al.***, 454 U.S. 90, 70 L.Ed.2d 262, 102 S.Ct. 172 (1981), in which Justice Sandra Day O'Connor voted with the majority to reverse the Orange County Superior Court Trial Judge for his having instructed the jury on the "beyond a reasonable doubt" criminal standard, rather than the "clear and convincing evidence" equity standard; yet, nevertheless, this Court refused to address the most-important question on the right at **Common Law** to close the

Mitchell Brothers' Santa Ana Theater as a public nuisance. See, in this regard, the trouble that existed at that time (1981) with regard to law enforcement as set forth in this Brief at **Appendix D**: **Title page** and **pages D-8** through **D-11** (and still exists, as can be seen from the recent opinions on Partial Birth Abortion Litigation). Note also, that the California Supreme Court refused to rule on "closure" because of this Court's restraint on that issue. See **Appendix D** at **page D-8** and **D-9**.

Three weeks before the decision in the above Santa Ana Abatement lawsuit, this Court handed down a 6-3 decision in ***Brockett v. Spokane Arcades, Inc.***, 454 U.S. 1022, 70 L.Ed.2d 468, 102 S.Ct. 557 (1981) (hereinafter referred to as ***Brockett 1981***) which upheld a 9TH Circuit Court of Appeals Judgment which rubber-stamped a U.S. District Court's improper interference with a Washington State Initiative Measure and, in effect, prevented all law enforcement in the 50 States from acting upon the historical **English Common Law** problem of the "Common Nuisance".

The Washington State Initiative in ***Brockett 1981*** contained the Public Nuisance Abatement Law that this Amicus had authored for the State of Washington, which was clearly severable. Amicus had also filed an Amicus Curiae Brief for the City of Santa Ana in support of the Washington State Initiative which contained a comprehensive review of the public nuisance abatement cases. See the copy lodged with the Clerk of this Court concurrently with the filing of this Amicus Curiae Brief in ***Stenberg v. Carhart***.

Notwithstanding the U.S. District Court's clear **11TH Amendment** violation of the ***Watson v. Buck*** **Abstention Doctrine**, this Court on November 9, 1981 affirmed by a 6-3 vote the 9TH Circuit's interference in ***Brockett 1981***, supra.

The Dissenting opinion which Chief Justice Warren Burger filed in ***Brockett 1981***, three weeks before the Court's decision in the abatement lawsuit in ***Cooper v. Mitchell***

Brothers' Santa Ana Theater, supra, explained what was the fundamental problem with such federal interference in 1981. See a copy of Chief Justice Burger's dissenting opinion at **Appendix E** to this Amicus Brief and in 454 U.S. at 1022-1023:

> " The Court today affirms a decision of the Court of Appeals holding unconstitutional a Washington statute with has yet either to be enforced in or construed by a Washington state court. I would abstain from decision until the Washington courts are given an opportunity to interpret the law which has been thus invalidated. This Court– and all federal courts– have enough to do without 'pre-empting' state courts on matters initially of state concern.
>
> " The Washington 'moral nuisance' law, Wash Rev Code §7.84.050 et seq. (Supp 1977)– a comprehensive statute directed at prohibiting the public sale and exhibition of obscene materials– was adopted as an initiative by the voters in the November 8, 1977, election. Before the statute was even certified by the Secretary of State, appellees, several corporations engaged in the exhibition, distribution, and sale of movies, books, and magazines, filed this action in the Federal District Court. On February 6, 1978, less than three months after the initiative's adoption, and apparently before it had ever been applied, the District Court declared the law unconstitutional. 449 F.Supp. 1145.
>
> " I have previously outlined the concerns that should lead a federal court to stay its hand in cases such as this, when litigants have deliberately avoided resort to the court of the state whose statue is being challenged. Vance v. Universal Amusement Co., 445 U.S. 308 . . . (1980) . . . The policies of federalism and comity militate in favor of affording state judges– who are as capable as are federal judges of enforcing the

> Constitution of the United States, and have taken the same oath to do so– the initial opportunity to consider the scope and validity of state statutes. This is particularly so when the state law under consideration has never been applied, and when its interpretation is uncertain; in such a case the state court's construction of the statute may obviate the need for adjudication of the federal constitutional issues, or the state court may resolve those issues as we would. . . .
>
> " . . . Even a cursory examination of the lengthy statute– which contains detailed definitions of 'lewd' or 'obscene' matter incorporating the standards of Miller v. California, 413 U.S. 15, 37 L.Ed.2d 419, 93 S.Ct. 2607 (1973), which provides for consolidation of the trial on the merits with the hearing on the temporary injunction and grants scheduling priority to cases brought under the statute, and which does not specify the defenses available in contempt proceedings– discloses that the state courts might well have construed the law so as to avoid each of these perceived deficiencies. It is ironic that, having exhibited no hesitation to construe the many provisions of this complex statue without guidance from the state courts, the Court of Appeals, wholly ignored an explicit severability clause and 'declined' to preserve those parts of the statute *not* found unconstitutional, demurring that the reconstruction required to salvage the statute would be better handled by 'the legislature of the State of Washington.' 631 F.2d at 139.
>
> " In sum, both the District Court and the Court of Appeals should have declined to act until the parties had exhausted available state remedies, at least absent a showing that resort to the state court would have been futile. There was no need whatever for federal courts to render a declaratory judgment as to the validity of a state law on which the state courts have not yet had an opportunity to speak and on behalf of parties against

> whom the law has not yet been applied. I would reverse and remand with directions to do now what should have been done initially." (Our emphasis.)

Four years later, this Court considered ***Brockett v. Spokane Arcades, Inc.***, 472 U.S. 491, 86 L.Ed.2d 394 at 408-410, 105 S.Ct. 2794 (1985) (hereinafter referred to as ***Brockett 1985***) which reconsidered the same statute and same problem. In this instance, Justice O'Connor reversed herself in a concurring opinion which hit the nail on the head. See her opinion in ***Brockett 1985*** at **Appendix F** to this Amicus Brief, which is highlighted in black stars, and note also, that Justice O'Connor in 1985, in voting the exact opposite of her vote in 1981 when she voted to affirm the 9TH Circuit's interference, told the 9TH Circuit additionally that:

> "Because I believe that the Federal Courts should have abstained and allowed the Washington Courts an opportunity to construe the state law in the first instance, I think the proper disposition of these cases would be to vacate the judgment of the Court of Appeals on that ground." (My emphasis.)

Here this Court also reversed itself and did a masterful evaluation of the same issue that faced the Court in 1981 and 1985.

This same problem is now before this Court in the abortion cases in the year 2000 and those cases should be dispatched as a single package in the same manner; i.e., vacate all of the federal judgments and send the Partial Birth Abortion Statutes (both criminal and civil) back to the state courts for an initial interpretation and construction by the state judiciaries.

In this case of the Nebraska Abortion legislation in ***Stenberg v. Carhart***, the State of Nebraska has the same public policy as the State of Washington. See at **Appendix F** to this Amicus Brief, Justice White's opinion in ***Brockett 1985***

(***Brockett v. Spokane Arcades, Inc.***, supra, 472 U.S. 491 at page 506, headnote 6; and ***Nebraska v. Divis***, supra, which is referred to at **pages 6-9** to this Amicus Brief). See also **Questions I** and **II** at **pages i-ii** to this Amicus Brief.

The ***Brockett 1985*** Proposition of Law expressed in Justice O'Connor's concurring opinion should control these abortion appeals. See, also, in this regard, Justice Kennedy's argument with Justice Tang in the two opinions in ***World Famous Drinking Emporium, Inc. v. City of Tempe, Arizona***, 820 F.2d 1079 (9TH Cir. 1987), copies of which are set forth at **Appendix G** to this Amicus Brief which reflects Justice Kennedy's **11TH Amendment** judgment. To achieve this end result, this Court should grant certiorari in ***Bill Pryor v. Summit Medical Associates***, No. 99-1041, which is squarely in point, and all of the other abortion cases, including ***Hope Clinic v. Ryan***, No. 99-1177, Petition for Certiorari filed January 14, 2000, and ***Hope Clinic v. Ryan***, No. 99-1152, Petition for Certiorari filed January 10, 2000, and ***Hope Clinic v. Ryan***, No. 99-1156, Petition for Certiorari filed January 10, 2000 and return them all to the state courts pursuant to the **11TH Amendment**.

In these abortion cases, it is abundantly clear that the Federal Court does not have **Article 3, §2** (statutory) federal subject matter jurisdiction as a matter of law, because the Attorney General, in no way is acting like a "rogue". Quite the contrary, he is performing his duties in a customary manner. The state courts should have jurisdiction under the **11TH Amendment of the U.S. Constitution**. This is the "either - or situation" that always exists when a federal court wrongfully deprives a state court of its right to **11TH Amendment** jurisdiction and the state challenges the federal court's assertion of subject matter jurisdiction. A state government can do nothing to repair the damage after the federal judgment declares, as in ***Brockett 1985***, that the federal interference in ***Brockett 1981*** was a constitutional error. This Court should correct this imbalance in the law by focusing on

and addressing the problem squarely with a grant of its writ of certiorari in ***Bill Pryor v. Summit Medical Associates***, supra, and as an acknowledgment of that which is the basis for the ***Younger - Huffman*** **Abstention Doctrines**; namely, ***Watson v. Buck***, supra, as the ***Watson v. Buck*** **Abstention Doctrine** is factored into the ***Younger*** and ***Huffman*** opinions.

In sum, the States of Alabama and Nebraska have the right of a sovereign state, under the **11TH Amendment**: **(1)** to enact a statute which criminalizes "Infanticide" and to outlaw the inhuman practice of partial birth abortion in those States; **(2)** to have that "Infanticide" criminal statute and the partial birth abortion proscription interpreted by the Alabama and Nebraska Supreme Courts and given a constitutional interpretation, if possible, under ***Watson v. Buck***, supra; **(3)** to rely upon the **Doctrine of Separation of Powers** which mandates that a state statute must be "saved", if possible, by the State Supreme Court, rather than struck by the federal courts (which cannot "interpret" a state statute); and **(4)** to answer any constitutional challenge in the State Court without being liable for attorney fees (compare **42 U.S.C. §1988**); where the exception created by ***Dombrowski v. Pfister***, supra, is not available because the statute is not unconstitutional in every sentence, clause, etc., nor is the Alabama or Nebraska Attorney General's conduct in the nature of that which is required for ***Dombrowski*** to be operational in the face of a ***Younger*** **Abstention Doctrine** challenge. Further, a decision by a federal court in the absence of the above process, is merely advisory.

Dated: **February 28, 2000**

Respectfully submitted,

James J. Clancy, Amicus Curiae
And Counsel of Record.

APPENDIX A

"DUE PROCESS AND EQUAL PROTECTION UNDER THE LAW"

A-1 **IN *CARHART V. STENBERG*, 11 F.SUPP.2D 1099, 1106 (D.NEB. 1998), THE U.S. DISTRICT COURT FOR THE DISTRICT OF NEBRASKA DESCRIBED THE PARTIAL-BIRTH ABORTION PROCEDURE USED BY FEDERAL PLAINTIFF CARHART ON A "HEALTHY" FETUS AS FOLLOWS ON A-1:**

A-2 **PICTURE AND ARTICLE FROM THE IRISH INDEPENDENT NEWSPAPER ONLINE, DATED OCTOBER 30, 1999, DESCRIBING AN OPERATION TO CORRECT "SPINA BIFIDA" ON A 21-WEEK-OLD FETUS, "SAMUEL ARMAS" ON A-2:**

A-7 **PICTURE FROM LIFE MAGAZINE, DECEMBER 1999, SHOWING AN OPERATION ON A "SICK" 24-WEEK-OLD FETUS IN JULY, 1999, ON A-7:**

(Reference: *Brief Amicus Curiae of James J. Clancy, etc.*, ... Page 1, lines 22, 38, ... Page 2, line 2.)

Due Process and Equal Protection Under the Law: The Abortionist

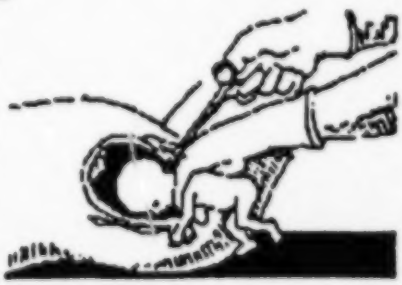
❶

". . . Carhart, using forceps, pulls the feet of the living fetus from the uterus into the vaginal cavity and then pulls the remainder of the fetus, except the head, into the vaginal cavity

❷

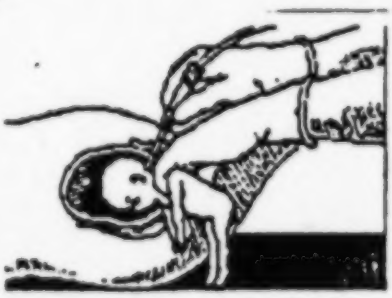
to a point where the base of the fetal skull is lodged in the uterine side of the cervical canal. At that point, the size of the head will not permit him to pull it through the cervical canal into the vaginal cavity.

❸



To decompress the fetal skull and evacuate the contents in order to pull it through the cervical canal, Carhart uses an instrument to either tear or perforate the skull to allow insertion of a cannula and removal of the cranial contents.

❹



Sometimes he will crush the skull rather than pierce it in order to reduce the size of the skull. Brain death occurs sometime during this two-to-three-second reduction procedure, but fetal heart function may continue for several seconds or minutes after the fetus's skull is decompressed."

Due Process and Equal Protection Under the Law:
The Physician

IRISH INDEPENDENT NEWSPAPER ONLINE
30 October, 1999,
http://www.independent.ie/1999/302/d20a.shtml

Holding hands

Take a good look at this picture. It's one of the most remarkable photographs ever taken. The tiny hand of a foetus reaches out from a mother's womb to clasp a surgeon's healing finger. It is, by the way, 21 weeks old, an age at which it could still be legally aborted. The tiny hand in the picture above belongs to a baby which is due to be born on December 28. It was taken during an operation in America recently. Paul Harris reports on a medical development in the control of the effects of spina bifida . . . and on a picture which will reverberate through the on-going abortion debate here.

Your first instinct is to recoil in horror. It looks like a close-up

of some terrible accident. And then you notice, in the centre of the photograph, the tiny hand clutching a surgeon's finger.

The baby is literally hanging on for life. For this is one of the most remarkable photographs taken in medicine and a record of one of the world's most extraordinary operations.

It shows a 21-week-old foetus in its mother's womb, about to undergo a spine operation designed to save it from serious brain damage.

The surgery was carried out entirely through the tiny slit visible in the wall of the womb and the "patient" is believed to be the youngest to undergo it.

At that age the mother could have chosen to have the foetus aborted. Her decision not to, however, led to an astonishing test not just of medical technology, but of faith.

Samuel Armas has spina bifida, which left part of his spinal cord exposed after the backbone failed to develop.

The operation was designed to close the gap and protect the cord, the body's motorway for nerve signals to the brain.

So, on an unborn patient no bigger than a guinea-pig, the operation was performed without removing the foetus from the womb.

The instruments had to be specially designed to work in miniature. The sutures used to close the incisions were less than the thickness of a human hair.

An ER-style crash-cart team was on constant standby in an adjoining room.

When it was completed, however, Samuel's battle for survival was only just beginning. Nor would the emotional battle his parents had already endured finish quite yet.

Julie and Alex Armas had been trying desperately for a baby.

Julie, a 27-year-old nurse, had suffered two miscarriages before she became pregnant with the child they intended to call Samuel Alexander if it was a boy

Then, at 14 weeks, she started to suffer terrible cramp. An ultrasound scan was carried out to show the shape of the developing foetus and its position in the womb.

When the picture emerged, it was the moment that every parent-to-be dreads. Their unborn son's brain was mis-shapen and his spinal cord was sticking out from a deformed backbone. He had spina bifida. They were devastated and "torn apart" said Alex, a 28-year-old jet aircraft engineer.

At that stage, and even weeks later, the couple could have decided to have the pregnancy terminated. In their home town of Georgia in the U.S. as in Britain abortion is routinely offered. Although accurate figures are not available, many parents accept. For Julie and Alex, who are deeply religious, it was not an option.

That didn't mean, of course, that they were not racked by pain at the thought that the child they had longed for was imperfect.

It also riddled them with guilt over whether they had effectively taken the decision to inflict their son with years of handicap, pain and suffering.

So, this being the United States, they turned to the internet for help.

Julie's mother found a website giving details of pioneering surgery being carried out by a team at Vanderbilt University in Nashville, Tennessee. Although the results have not yet been endorsed in medical journals, they looked encouraging to Mr. And Mrs. Armas.

Their doctor put them in touch with Dr. Joseph Bruner (it is his finger in the photograph). A race against time had begun.

Because it affects the spinal cord, spina bifida can lead to a

condition that causes brain damage. Mr and Mrs. Armas were told that if they were to avoid the condition, which was not then present in Samuel, they had to act fast.

"I wasn't concerned about a child who couldn't walk," said Julie, "but I want a child who knows me."

The theory behind the surgery is that attention to the spine disorder before the baby is born prevents or limits brain damage, and gives a better chance of healing. It does not cure spina bifida, but it is said to provide a strong chance of limiting the damage through early intervention.

The risks, however, are enormous. Controversy surrounds the use of such surgery because it goes against the general medical rule that the risk should not outweigh the benefit.

Mr and Mrs Armas were fully aware that if anything went wrong, no attempt would be made to deliver Samuel by Caesarean section.

Medical science does not yet have the capability to keep a 21-week-old foetus alive outside the womb. The crash-cart was on standby for Julie, not Samuel.

"If he dies, that's horrible for me and for us," said Julie before she went into theatre. Wiping tears she added: "But not for him. The worst thing might be if we don't do this, and this is standard treatment when he's 21, and he says: 'Why didn't you know about that?' And we say: 'We did, but we didn't do it for you.' "

The other major dangers were turning him in the womb to get his back in line with an inch-long cut in the wall, through which Dr. Bruner would operate, and that the surgery might involve releasing the fluid around Samuel.

The movement posed the risk of sending Julie into labour contractions, which would have been fatal for Samuel.

Thus, one morning at the beginning of last month, Dr. Bruner

could be heard urging his team to keep quiet. "Shh!" he said. "You'll wake the baby!"

Robert Davis, who reported on the operation for U.S.A. Today newspaper, said the lesion that exposed Samuel's spine was found low on his backbone, decreasing the chance of nerve damage.

Although Samuel is believed to have been the youngest patient for such an operation, it was apparently routine enough for Dr. Bruner and paediatric neurosurgeon Noel Tullpant to talk about the weather during the opera ion.

An hour later, the womb is gently eased back into place. "Beautiful," said one of the technicians and relief swept the room.

Julie was allowed home with Alex within days. The baby is due on December 28.

He has not yet felt the touch of his mother's skin against his own and he knows nothing of life outside her womb. But perhaps Samuel Alexander Armas will be able to shake Dr. Bruner's hand again.

The calm before the abortion debate storm

By Justine McCarthy. Nobody could be unmoved by the powerful image of this tiny finger clinging to the surgeon's hand. A hand that can create modern miracles and save lives that might otherwise be doomed before they even begin. This picture is an emotive and compelling argument against the termination of abnormal pregnancies and it appears as Ireland braces itself for yet another visitation of the debate.

As the range of options outlined in the government Green Paper are being considered for the next instalment in the Irish debate, there is a sense of an uneasy calm before the storm. With assisted abortion technically legal here under the Supreme Court ruling in the X Case, pro-life organisations still continue to

lobby for yet another referendum on the substantive issue.

Dana's election to the European parliament last summer was indicative of the strong pro-life undercurrent in her constituency of Connacht-Ulster. Suggestions that similar candidates might be fielded throughout the country at the next general election are predicated on the belief that a referendum is still a possibility.

In fact, Dana indirectly raised the subject in Europe this week when she put down an amendment to the Union's budget seeking to end the funding monopoly enjoyed by the European Women's Lobby. She wanted to give some of the allocated ££480,000 to the World Movement of Mothers, an organisation Dana claimed to know little about but which others described as pro-life. The European Women's Lobby, an umbrella organisation that lobbies the E.U. on behalf of various womens groups throughout the Union, claimed that the proposed cut in its funding could jeopardise the jobs of its 10-strong staff.

Though, ultimately, no vote was taken on that amendment, it focussed the parliament's minds on the issue of abortion once again.

Nearly 6,000 Irish females are expected to travel to Britain this year for abortions. In this country, however, the debate has traditionally been concerned with crisis pregnancies rather than abnormal foetal development. In that respect, this extraordinary photograph may have more relevance to the debate in Britain where termination is legally available at 21 weeks - the age of the world's youngest known patient.

(End of Article)

LIFE MAGAZINE, December, 1999

Beforehand, Dr. Joseph Bruner gently lifts the right arm of the 24-week-old fetus in Trish Switzer's womb during surgery at Vanderbuilt University Hospital in July, 1999.

APPENDIX B

NEWSPAPER ARTICLES REPORTING A 1998 SCIENTIFIC "MISHAP" WHICH HAS RECENTLY BEEN BROUGHT TO THE PUBLIC'S ATTENTION WHEREIN IT HAS BEEN REVEALED AND ESTABLISHED BY IRREFUTABLE "LIVING" PROOF THAT "AN ENTIRE PERSON" WITH A SEPARATE AND DISTINCT D.N.A. IDENTIFICATION IS "CREATED" AT THE FERTILIZATION OF THE FEMALE EMBRYOS BY THE MALE SPERM, AND BEFORE THE IMPLANTATION IN THE WOMB OF THE FEMALE, WITH THE ANALYSIS OF THOMAS F. FEE AND OTHER NEWS ARTICLES OF SUCH "MISHAP".

(Reference: *Brief Amicus Curiae of James J. Clancy, etc.*, ...Page 1, line 22, ... Page 2, line 1.)

EDITOR'S NOTE

THE FOLLOWING PAGES WERE POOR HARD COPY AT THE TIME OF FILMING. IF AND WHEN A BETTER COPY CAN BE OBTAINED, A NEW FICHE WILL BE ISSUED.

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THE OREGONIAN 4/16/99

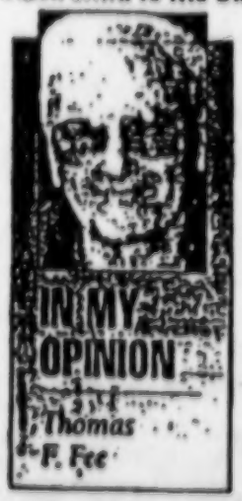
Embryo mix-up shows why Roe-Wade needs fixing

High Court should revisit 1973 ruling with eye on new technology, findings and DNA evidence on life in womb

The Oregonian, on March 31, published a news item headlined "Fertility mix-up causes anguish." According to this story, Dr. Lillian Nash, a fertility doctor in midtown Manhattan, inadvertently implanted embryos from a black couple, Deborah Perry-Rogers and Robert Rogers, along with the embryos from a white couple, Donna and Richard Fasano, into Donna Fasano's uterus.

Nash discovered the mix-up early in the pregnancy and told both the Rogerses and the Fasanos what had gone wrong. Donna Fasano underwent an amniocentesis, which determined that she was carrying two healthy babies, and a DNA test, which determined that only one of them was genetically hers. Since both babies were perfectly healthy, Donna Fasano decided to carry them to term, and in December 1998 she gave birth to two boys — one white, one black.

The Fasanos and the Rogerses and their attorneys are working together in a spirit of love and goodwill to resolve the issue and pending the results of a DNA test will give the black child to his biological parents to raise.



All's well that ends well?

Not quite. The birth of these two boys seems to refute some of the favorite lies of the pro-abortionists and the Supreme Court's decision that there is no "personhood" prior to birth.

Lie No. 1: "Nobody knows when life begins."

Obviously, the life of the black baby began at fertilization, and he was alive before implantation in the womb of Donna Fasano. His white mother's womb gave him a place for nourishment and to develop until birth. She neither gave nor took away anything from his body. All that he is now was all there at the moment of conception.

Lie No. 2: "It's her body."

The black baby obviously was not her body. The egg and sperm and fertilized embryo belonged to the Rogerses, and DNA proves that babies are separate and distinct persons and not a part of the mother's body.

Lie No. 3: The infamous Roe vs. Wade decision of 1973 stated that prior to birth there is no "personhood," and in the "penumbras" (shadow or gray area) of the Constitution lay a woman's right to privacy and abortion.

Since the black baby is the same "person" today as he was prior to implantation in the womb, he must have been the same "person" at his conception as he is now. So why doesn't the Constitution protect his right to "life, liberty and the pursuit of happiness"? The same fallacious argument of a "non-person" was used prior to the Civil War to deny blacks full citizenship.

Fortunately for all, Donna Fasano carried both babies to term. But suppose the white mother had aborted the black baby? Since the black baby wasn't hers (the egg and sperm belonged to the Rogerses), could she then have been prosecuted for murder? There have been cases alleging manslaughter or murder of an unborn baby being killed in the womb in automobile accidents, drive-by shootings and other deadly accidents involving a pregnant mother.

This birth calls into question the legitimacy of the Roe vs Wade decision. The Supreme Court should be required to revisit it based on present-day technology, DNA evidence and modern science's new findings of life in the womb.

Life begins at conception. The Rogerses know it. The Fasanos know it. All parents know it. It's time for the Supreme Court to correct its error before another 36 million babies die in the womb.

Thomas F. Fee of Sunriver is a member of the board of directors of Oregon Right to Life.

http://search.washingtonpost.com/w...O/19990330/V000893-033099-idx.html

Woman to Give Up Baby After Mix Up

Tuesday, March 30, 1999; 8:09 a.m. EST 3/30/99.

NEW YORK (AP) -- A white woman who gave birth to a black child after she was accidentally implanted with another couple's embryos will surrender the baby to the couple who are believed to be the biological parents, her lawyer said.

Donna and Richard Fasano will give up the 3-month-old boy "because we love him," they said Monday in a statement.

"We both want what's in the best interest of the child," Mrs. Fasano said.

Mrs. Fasano gave birth Dec. 29 to two boys, one black and one white.

The Fasanos decided to raise the white child and allow Robert and Deborah Perry Rogers to raise the black child if DNA tests confirm that they are his biological parents, said Mrs. Fasano's lawyer, Ivan Tantleff. They hope to get visitation rights.

"The Fasanos have reared, loved and cared for both children as their own," he said. "(Mrs. Fasano) doesn't look at them as white and black. She looks at them as her sons. She is torn apart by this."

The Rogerses, from Teaneck, N.J., sued over the case, seeking custody.

Court papers said that last April, 71-year-old Dr. Lillian Nash, in her Manhattan office, implanted eggs fertilized by their husbands in the two women's uteruses. Each couple had tried for years to conceive a child but had been unsuccessful.

Mrs. Rogers did not become pregnant from the procedure. Mrs. Fasano, however, became pregnant with twins.

The mix-up was discovered two weeks into her pregnancy. The doctor said several of Mrs. Rogers' embryos, deemed unsuitable for storage for use in a future attempt at pregnancy, accidentally were implanted in Mrs. Fasano along with her own.

Mrs. Fasano opted to go ahead with the pregnancy after learning the twins were healthy, even though one was not genetically hers, Tantleff said.

Mrs. Rogers was astonished by the news that the Fasanos would relinquish the black child, said her lawyer, Rudolph Silas.

"She was very excited to hear the good news and overwhelmed after so many failed efforts to conceive," he said.

The Fasanos were expected to meet the Rogerses, for the first time, in a few days.

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SUNRIVER REALTY 006
http://search.washingtonpost.com/w...O/19990331/V000551-033199-idx.html

Woman to Give Up Baby After Mix Up

By Beth J. Harpaz
Associated Press Writer
Wednesday, March 31, 1999; 4:12 a.m. EST 3/31/99

NEW YORK (AP) -- They are brothers, twins born of the same womb. One is black, the other white. It is a baby-switching case with a twist -- these babies were switched before birth.

Now the only mother either 3-month-old boy has ever known will return the child who does not share her DNA -- the black child -- to his genetic parents.

"We're giving him up because we love him," said Donna Fasano, 37, in a handwritten statement supplied by her lawyer Tuesday.

The babies ended up in the same womb because a doctor at a fertility clinic apparently mixed up Mrs. Fasano's embryos with those of another couple.

"Both of these boys are beautiful -- two precious, normal little boys," said her lawyer, Ivan Tantleff. "They sit in the swing together. They sit in the tub together."

The case began April 24, 1998, when Mrs. Fasano underwent embryo implantations in the Manhattan offices of Dr. Lillian Nash. Another couple, Deborah Perry-Rogers and Robert Rogers, sought help from the same clinic at the same time.

Both women underwent in vitro fertilization, in which their own eggs fertilized by their husbands' sperm were implanted into the uterus. Only Mrs. Fasano became pregnant.

Doctors discovered a problem a few weeks into Mrs. Fasano's pregnancy, when an amniocentesis exam revealed that although she was carrying twins, only one was her genetic son.

The clinic had apparently inserted some of Mrs. Rogers' eggs into Mrs. Fasano's uterus along with her own. Since both babies were healthy, Mrs. Fasano decided to carry them to term, her lawyer said.

The babies were born in December. Mrs. Fasano said she didn't know the other parents' identity until the Rogerses sued Nash, two other doctors and the Fasanos on March 16.

"This wasn't my doing," Mrs. Fasano said in her statement. "People with infertility problems should be able to go to their doctors and trust them to do the right thing. To them it may be a job; to me it's my life."

The state's health department is investigating the incident. A call to Nash's clinic was not returned Tuesday.

Tantleff said he is trying to arrange for visitation rights for the Fasanos "so the boys grow up to know that they are brothers."

Mrs. Perry-Rogers, a nurse, and her husband, a teacher, are amenable to visitation, their lawyer said Tuesday. "It's in the children's best interest," said Rudolph Silas.

Silas said his clients will likely get custody of the little boy in a few weeks, after DNA tests and legal papers are completed.

"My clients are both ecstatic," Silas said. "They are the proud parents of a 3-month-old baby boy. Of course there's some mixed emotions in the manner in which it's been brought to this point. But they're happy she made the decision she's made."

George Annas, a professor of health law at the Boston University School of Public Health, said Mrs. Fasano's decision "seems like a reasonable solution but it's got to be heart-wrenching."

The Fasanos' phone was out of service Tuesday and the Rogerses did not return a call. Their lawyers said the parents did not want to comment, and would not divulge the babies' names.

The Rogerses' suit accuses Nash, Dr. Dov B. Goldstein and Dr. Michael Obasaju of negligence, malpractice and breach of contract. Goldstein ran a different clinic where the Rogerses stored their embryos.

Lawyers agreed that the woman who gives birth is legally considered the child's mother regardless of DNA.

"I'm glad we don't have to contest that and litigate," Silas said "Her decision to do it voluntarily saves us a lot of heartache."

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3-31-99
THE OREGONIAN.

Fertility mixup causes anguish

■ Two couples struggle to sort out one of the more bizarre controversies in the history of reproductive technology

By MICHAEL GRUNWALD
The Associated Press

NEW YORK — Donna and Richard Fasano, a white couple from Staten Island, N.Y., were desperate to have a baby.

Deborah Perry-Rogers and Robert Rogers, an African American New Jersey couple, wanted a child, too.

Both couples visited the same fertility doctor in midtown Manhattan. Now it looks like both couples are going to get their wish.

But first they are struggling to sort out one of the more bizarre controversies in the history of reproductive technology.

In April, the doctor accidentally implanted embryos from the Rogerses, as well as the Fasanos, into Donna Fasano's uterus, and in December, she gave birth to two boys — one white, one African American. Monday, the Fasanos reluctantly agreed to give the African American infant to the Rogerses, as long as they and his "twin" brother are assured visitation rights.

This tale of two babies raises thorny questions about race, genetics, parenthood and the law, and provides a disturbing glimpse of the virtually unregulated world of in vitro fertilization.

"This is a kitchen-sink story; it raises almost every tough issue that has arisen from the advances in reproductive medicine," said Glenn McGee, a professor of bioethics at the University of Pennsylvania. "God help the judge that gets this case."

The Rogerses have filed a lawsuit against the Fasanos and the fertility specialist, Lillian Nash. They will drop the Fasanos as defendants once they take custody of the child that grew from their embryo.

Deborah Perry-Rogers had the couple's embryos implanted in her uterus as well but did not become pregnant.

The Fasanos also plan to file a malpractice suit against Nash sometime over the next few days. . . .

DNA tests pending

Donna Fasano said in a statement that the couple decided to surrender custody, pending a confirmatory DNA test, because "we both want to do what's in the best interest of the child." According to their lawyers, both couples are thrilled to be parents but outraged and distraught over the mistake at Nash's clinic.

"People with infertility problems should be able to go to their doctors and trust them to do the right thing," Fasano said in her statement. "To them it may be a job; to me, it's my life. She may have given me two beautiful babies but she destroyed their lives."

Nash, 71, did not return calls.

This was not the first mishap in the $1 billion-a-year high-tech birthing industry, which now accounts for about 20,000 annual live births, up nearly 450 percent in seven years.

In 1992, a Fairfax County, Va., doctor named Cecil Jacobsen was convicted of fraud and perjury after he secretly impregnated dozens of women with his own sperm.

In 1994, the University of California shut a fertility clinic after doctors were caught stealing harvested eggs for their research. In Utah, an egg was accidentally fertilized with the wrong man's sperm.

But this is the first known mix-up over gametes that has ended up with a woman giving birth to children of different races.

George Annas, a professor of health law at Boston University, said the custody question would have been quite clear had the Fasanos decided to fight it: Every state but California considers the birth mother, or "gestational mother," not the "genetic mother," to be the legal mother.

Good news, and bad

The saga began April 24, when Nash implanted the Fasanos' fertilized eggs into Donna Fasano's uterus, but inadvertently implanted some of the Rogerses' embryos as well. A month later, she contacted the Fasanos with the good news: Donna was pregnant. Two weeks later, she contacted the Fasanos and the Rogerses with the bad news: something had gone terribly wrong.

Fasano underwent an amniocentesis, which determined that she was carrying two healthy babies, and a DNA test, which determined that only one of them was genetically hers.

On Dec. 29, Donna Fasano gave birth to her unprecedented set of genetically distinct "twins." They have spent their first three months in the same crib, sharing the same clothes, sharing the same life. But after the Rogerses filed their suit two weeks ago — and after both couples agreed through their attorneys that the boys should grow up knowing they are brothers — the Fasanos made their anguished choice. "We're giving him up because we love him," Donna Fasano said.

Roe vs. Wade: A botched ruling that must be resolved

The Bulletin 5/14/99

A certain professor who teaches students who aspire to become speech pathologists begins by showing them the development of the various organs involved in speech. When he shows his class an ultrasound picture of the development of the palate in an unborn baby, it is not uncommon for one or two women in his class to have tears in their eyes, or to say to him afterward that they have had an abortion and were very much affected by seeing what an unborn baby looks like.

For too long we have been led to believe that an abortion is the removal of some unformed material, something like having an appendix operation. The very expression "unborn baby" has almost disappeared from the language, being replaced by the more bloodless and antiseptic term "fetus."

Many vocal advocates who declare themselves "pro-choice" do not want women to have the choice of knowing just what they are choosing before having an abortion. Ferocious opposition has stopped the showing of pictures of an abortion in process — even in schools or colleges that show movies of naked adults performing various sex acts. Still photographs of aborted fetuses have been banned as well.

Thomas Sowell

The particularly grisly procedure know as "partial-birth abortion" cannot even be referred to in much of the media, where it is called a "late-term abortion" — another bloodless term and one that shifts the focus from what happens to when it happens.

What happens in a partial-birth abortion is that a baby who has developed too far to die naturally when removed from his mother's body is deliberately killed by having his brains sucked out. When th is done, the baby is not completely out his mother's body because, if he were, doctor would be charged with murder. There is no medical reason for this pro dure, which has been condemned by t American Medical Association. There i only a legal reason — to keep the doct and the mother out of jail.

All this is smoothly covered over in the media by calling such actions a "la term abortion" and refusing to specify what happens. Such patterns of determined evasions and obfuscations show that "pro-choice" in practice often reall means pro-abortion. Knowledge is the first thing being aborted.

Philosophical questions about whe life begins may preoccupy some people both sides of the abortion controversy. But the raw physical facts of what hap pens in various kinds of abortion have turned many others, including physicians, from being pro-abortion to being anti-abortion. One doctor who had performed many abortions never performed another one after seeing an ultrasound movie of the baby's reactions.

With most other medical procedures, "informed consent" is the watchword. But, when the issue is abortion, great efforts are made to keep "choice" from becoming too informed.

Politically and legally, the abortion issue is too complex for any easy resolution. We have gone through a quarter of a century of bitter controversy precisely because the Supreme Court went for an easy resolution back in 1973 with the Roe vs. Wade decision.

Before then, various states had made differing efforts to wrestle with and balance the weighty concerns on both sides of the abortion issue. But Supreme Court Justice Harry Blackmun rushed in where angels fear to tread, washed down with the blatant lie that this was based on the Constitution.

Far from settling things, Roe vs. Wade has led to polarization and escalating strife all across the country, including bombings and assassinations. It has corrupted the media, academia and other sources that are supposed to inform us, but which have instead become partisan organs of political correctness.

However this highly charged issue is ultimately resolved surely honesty must be part of that resolution. Political catchphrases like "a woman's right to do what she wants with her own body" cannot be applied to situations where a baby is killed at the very moment when he ceases to be part of his mother's body.

One of the few signs of hope for some ultimate resolution is that most people on both sides of this controversy are not happy about abortions. The women who shed tears at the sight of an unborn baby may not be politically committed to either side of this issue, but their feelings may be part of what is needed to bring opposing sides together.

Sowell is a senior fellow at the Hoover Institute in Stanford, Calif.

A8 San Francisco Chronicle

5/22/99

Genetic Family Gets Boy After Clinic's Error

Black baby returned by white birth mom

ASSOCIATED PRESS

NEW YORK – A black baby born to a white couple because of a mix-up during implantation of embryos at a fertility clinic has been handed over to his genetic parents, court papers filed yesterday revealed.

The baby, born December 29 to Donna and Richard Fasano of New York, was given to the black couple, Deborah Perry-Rogers and Robert Rogers of Teaneck, N.J., on May 10 during a visit to the Fasano home. The baby is named Joseph.

A lawyer for the Fasanos, David Cohen, said the custody exchange was "very emotional, very strained, very difficult. This woman (Donna Fasano) had carried the baby to term, and had cared for him for four months."

The custody change came to light in papers filed in Manhattan's State Supreme Court where the Rogerses asked for declarations that they are the infant's parents and that they have permanent custody of him.

Donna Fasano, 37, also gave birth to a white boy – Joseph's fraternal twin – who is genetically hers and her husband's. The Fasanos have said they wanted the boys to grow up knowing each other as brothers.

"There has been a visitation agreement worked out, but I'm not going to talk about the details of it," Cohen said.

Deborah Perry-Rogers, 33, is a nurse; her husband, 35, is a teacher. Both the Fasanos work in finance.

The embryo imbroglio happened at the Manhattan fertility clinic of Dr. Lillian Nash. Donna Fasano and Deborah Perry-Rogers had stored fertilized eggs at the clinic, and both visited on April 24, 1998, for embryo implantation.

Nash's associate, Dr. Michael Obasaju, has admitted that he mistakenly put some of Deborah Perry-Rogers' embryos into a catheter used to implant Donna Fasano's embryos, a state Health Department report says.

The report concludes that Obasaju could have told Nash to stop the procedure immediately. Instead, investigators say, he prepared a second batch with the correct embryos and handed them to Nash for implantation.

He said he remained quiet about his original error because the wrongly implanted embryos were "lower in quality" and he did not believe they would grow.

While New York officials have maintained that the "real error" was made by the embryologist, the Health Department report also found that numerous procedural violations had taken place at the Manhattan clinic where the mistake occurred, and it cited Nash for failing to properly oversee Obasaju.

The Fasanos and the Rogerses have sued Nash and Obasaju for unspecified damages.

THE NEW YORK TIMES CONTRIBUTED TO THIS REPORT.

SATURDAY
July 17, 1999

News Digest

Black couple gets custody of baby

NEW YORK — A justice of the state Supreme Court in Manhattan ruled Friday that a black baby who was born to a white Staten Island woman after an embryo mix-up at a fertility clinic belongs in the permanent custody of his biological parents.

Justice Diane S. Lebedefv ruled that the biological parents, Deborah Perry-Rogers and Robert Rogers, a black couple from Teaneck, N.J., should have custody of the 8-month-old boy named Akiel.

The baby's birth parents, Richard and Donna Fasano, had filed suit to force the Rogerses to live up to a visiting agreement. Fasano gave birth to the boy and to her own biological son after a Manhattan fertility clinic mistakenly placed fertilized embryos from both couples in her womb.

SAN FRANCISCO CHRONICLE 5/27/99

A Wisconsin state appeals court judge has ruled Deborah Zimmerman (shown here at left with her attorney, Sally Hoelzel, in 1997) cannot be charged with attempted murder because a fetus is not a human being.

Associa

Fetal-Rights Case Dismissed – Mom Who Drank Goes Free

ASSOCIATED PRESS

MADISON, Wis. – A state appeals court yesterday threw out the case against a woman accused of trying to drink her fetus to death, ruling that she could not be charged with attempted murder because a fetus is not a human being.

In a case closely watched by civil libertarians and people on both sides of the abortion debate, the Wisconsin Court of Appeal ruled in favor of Deborah Zimmerman, whose daughter was born in 1996 with a blood-alcohol level of 0.199 percent, twice the level considered intoxicated under Wisconsin law.

"The term 'human being' was not intended to refer to an unborn child, and Deborah's prenatal conduct does not constitute attempted first-degree intentional homicide and first-degree reckless injury," the court ruled.

Zimmerman spent the day her daughter was born drinking at a bar, building a blood-alcohol level exceeding 0.30 percent at the time of birth.

At the hospital, Zimmerman allegedly told a nurse: "I'm just going to go home and keep drinking and drink myself to death, and I'm going to kill this thing because I don't want it anyways."

Zimmerman's baby was born limp and pallid. Zimmerman's lawyer, Sally Hoelzel, said the girl – now 3 years old and living in foster care – is healthy.

Zimmerman has yet to stand trial. She took her case to the appeals court after a trial-level judge refused to dismiss the charges. Zimmerman contended that her alcohol abuse during pregnancy was directed toward her own body and the fetus she carried – not another human being.

Authorities argued that Zimmerman should be prosecuted for attempted murder based on the state's "born alive" rule. The law says a person can be charged with murder if he or she harms a pregnant woman and her fetus is born alive and then dies. Prosecutors argued that the law

should be extended to attempted murder if a fetus is born with injuries but survives.

The appeals court ruled yesterday that was not the Legislature's intent.

Zimmerman has been in prison for violating her bail conditions in the case and is due for release in September.

Zimmerman's attorneys and civil libertarians had argued that if the state succeeded, women would risk criminal charges if they did anything – such as smoking or drinking – that could harm a fetus.

Simon Heller, litigation director for the Center for Reproductive Law and Policy, which handled Zimmerman's defense, said there have been many rulings that a fetus is not a human being, including the U.S. Supreme Court's Roe vs. Wade decision legalizing abortion.

The South Carolina Supreme Court, however, ruled that a viable fetus is a person under a statute punishing child abuse, he said. The court did not apply it to murder laws in that case.

APPENDIX C

CLARENCE F. MURPHY V. PLANNED PARENTHOOD OF GREATER IOWA, INC., ET AL.,
SCOTT COUNTY DISTRICT COURT NO. 94716:

FIRST AMENDED PETITION FOR A DECLARATORY JUDGMENT AND AN INJUNCTION TO PREVENT PLANNED PARENTHOOD'S USE OF LAND FOR THE OBNOXIOUS AND OFFENSIVE TRADE OF ABORTION AND INFANTICIDE IN VIOLATION OF: (1) PETITIONER MURPHY'S SUCCESSFUL STATUTORY PROTEST PURSUANT TO BETTENDORF ZONING CODE §24.2 AND §24.4; AND (2) PARAGRAPH 3 OF THE RECIPROCAL RESTRICTIVE AND PROTECTIVE COVENANTS THAT RUN WITH BOTH PETITIONER MURPHY'S LOT 3 OF BLOCK 4 AND THE ADJOINING LAND OF PLANNED PARENTHOOD TO THE SOUTH, WHICH LIES BETWEEN BLOCK 4 AND BLOCK 1 AND WITHIN THE QUAD CITY TECHNOLOGICAL CENTER, A PLANNED UNIT DEVELOPMENT (P.U.D. ZONE).

(Reference: *Brief Amicus Curiae of James J. Clancy, etc.*, ...Page 13, footnote 1,
..... Page 16, footnote 3,
..... Page 18, footnote 5,
..... Page 19, line 14.)

IN THE IOWA DISTRICT COURT
FOR SCOTT COUNTY

	)	**Case No. 94716**
Clarence F. Murphy,	)	
Plaintiff,	)	**First Amended Petition for a**
	)	**Declaratory Judgment and**
vs.	)	**an Injunction to Prevent**
	)	**Planned Parenthood's Use of**
Planned Parenthood of	)	**Land for the Obnoxious and**
Greater Iowa, Inc.	)	**Offensive Trade of Abortion**
Defendant,	)	**and Infanticide in Violation**
	)	**Of: (1) Petitioner Murphy's**
and	)	**Successful Statutory Protest**
	)	**Pursuant to Bettendorf**
The City of Bettendorf,	)	**Zoning Code §24.2 and**
Iowa	)	**§24.4; and (2) Paragraph 3**
Defendant,	)	**of the Reciprocal Restrictive**
	)	**and Protective Covenants**
and	)	**That Run with Both**
	)	**Petitioner Murphy's Lot 3 of**
Middle Road Investors, Inc.	)	**Block 4 and the Adjoining**
Defendant.	)	**Land of Planned Parenthood**
	)	**to the South, Which Lies**
		Between Block 4 and Block 1
		and Within the Quad City
		Technological Center, a
		Planned Unit Development
		(P.U.D. Zone).

COMES NOW Plaintiff, Clarence F. Murphy, and for his Petition for a Declaratory Judgment and Injunction, states as follows:

PARTIES

1. Petitioner Clarence F. Murphy and his wife Hwa Cha Murphy (hereinafter called "Petitioner Murphy" and "Murphy") are citizens of Bettendorf, Iowa, who reside at 2835 Willow Drive, Bettendorf, Iowa. Murphy and his wife are the owners of two twelve plex apartments known as 2655 Tech Drive, Bettendorf (a.k.a. Lot 3, of Block 4) and 2750 Tech Drive, Bettendorf (a.k.a Lot 2 of Block 2) of the Quad City Technological Center, a planned unit development and hold title to such properties in the name of Murpak Enterprises, Inc., a Delaware Corporation which is wholly owned by Murphy and his wife Hwa Cha.. See **Exhibit** pages **C-3** and **C-4**, infra.

2. Lot 3 of Block 4 was conveyed by Middle Road Investors, Inc. (hereinafter called "Defendant Middle Road" and "Middle Road") to Petitioner Murphy by Warranty Deed dated January 30, 1976, which was filed with the Office of Scott County Recorder on February 18, 1976 as Document 2524-76 (after the Iowa Supreme Court decision in ***Kuntz*** [infra, 1975] and ***Harris***, [infra, 1975]). Defendant Middle Road had acquired its ownership by Warranty Deed from the City of Bettendorf (hereinafter called "Defendant Bettendorf" and "Bettendorf") on the same date (February 18, 1976) in partial performance of a contract dated November 7, 1972 and recorded in the Office of Scott County Recorder as Document 1947-73. The abstract for the Plat of Lot 3 of Block 4, which is attached as **Exhibit A** and incorporated by reference herein, contains the following certification at page **A-3**, last paragraph:

> " NOW THEREFORE, Middle Road Investors, Inc., and the City of Bettendorf, Iowa, hereby declare that the real property described in the Surveyor's Certificate is and shall be held, transferred, sold, conveyed and occupied subject to the Restrictive and Protective Covenants heretofore filed on April 11, 1973, as Document #5134-73 with the platting of Block 1 of

> Quad City Technological Center shall remain in effect and apply to Lot 3 of Block 4 as platted herein.
>
> " Dated this 20th day of January, 1976.
>
> MIDDLE ROAD INVESTORS, INC.
> By Robert D. Danico, President
> By C.J. Munson, Secretary
>
> CITY OF BETTENDORF, IOWA
> By William C. Glynn, Mayor
> By Margaret W. Lake, Deputy City Clerk"

3. Lot 2 of Block 2 was conveyed to Petitioner Murphy and his wife by Ed Speer Construction, Inc. by Warranty Deed dated February 25, 1994 and filed on March 4, 1994 in the Office of Scott County Recorder as Document No. 7001-94 in full performance on that real estate contract dated June 1, 1979 and recorded on January 23, 1980 in the Office of the Scott County Recorder as Document No. 1155-80. The abstract for the Plot of Lot 2 of Block 2 which is attached as **Exhibit B** and incorporated by reference herein shows that the Defendant Bettendorf was an owner with Middle Road of Block 2 and contains the following certification at page **B-3**, last paragraph:

> " NOW THEREFORE, Middle Road Investors, Inc., and the City of Bettendorf, Iowa, hereby declare that the real property described in the Surveyor's Certificate is and shall be held, transferred, sold, conveyed and occupied subject to the Restrictive and Protective Covenants heretofore filed on April 11, 1973, as Document #5134-73 with the platting of Block 1 of Quad City Technological Center shall remain in effect and apply to Lot 2 as platted herein. In addition thereto, each lot owner of Lots in said Block 2 shall share the common driveways into said Block 2 from Tech Drive and P.U.D. Drive.

" Dated this 1st day of July, 1975.

MIDDLE ROAD INVESTORS, INC.
By Robert D. Danico, President
(Corporate Seal) By C.J. Munson, Secretary

CITY OF BETTENDORF, IOWA
By William C. Glynn, Mayor
(Seal of City of Bettendorf, Iowa)
By James W. Strieck, Clerk"

4. Defendant Planned Parenthood of Greater Iowa, Inc. (hereinafter called "Defendant Planned Parenthood" and "Planned Parenthood") is the present owner of a parcel of land within the metes and bounds of the Planned Unit Development (hereinafter "P.U.D. Zone") known as Quad City Technological Center to the City of Bettendorf, lying between Block 1 and Block 4, the Lot having been purchased by Defendant Planned Parenthood on April 14, 1997. The northern boundary of the Planned Parenthood property abuts and forms the southern boundary of Lot 1, Lot 2 and Lot 3 of Block 4. The southern boundary of the Planned Parenthood property abuts and forms the northern boundary of Block 1, and the northern boundary of the right of way know as Happy Joe Drive, as shown on the two maps which are attached to this Petition as **Exhibit C** and pleaded by incorporation herein. At the time of the platting of Lot 3 of Block 4, it was the expressed intention of Defendant Bettendorf and Defendant Middle Road, as the developers of the Quad City Technological Center to the City of Bettendorf, to place the same "restrictive" and "protective" covenants that were attached to Block 1 on the future development and platting of the P.U.D. Zoned Planned Parenthood property, which was owned in fee simple by Defendant Bettendorf and Defendant Middle Road, so that the "benefits" and "restrictions" on all of the said Lots in said land development were "reciprocal", as expressed and accomplished in the recording of the platting of Blocks 1 through 6 as a whole, see **Exhibit D** to this Petition (infra, at page **D-3**, the first paragraph and page **D-6**, paragraph

11) and pleaded by incorporation herein. Petitioner avers that the terms of the restrictive and protective covenants were extended by the developer, Defendant Middle Road, for a finite period of 10 years to the year 2003 to provide time to complete the platting of the plan as a whole, so that upon the completion of that land development, each of the lots within the P.U.D. Zone would have and enjoy the same benefits and burdens.

5. By the platting of Lot 3 of Block 4, Petitioner Murphy's property was burdened by the restrictive covenants but did not, at that time, receive the promised reciprocal benefits (the "protective" covenants) from the adjoining Planned Parenthood property the title to which, was thereafter "clouded" by the "equitable protective servitude" which attached to Murphy's land to the north. The "restrictive" and "protective" covenants in the platting of Lot 3, Block 4 are writings which establish a bilateral contract between Defendant Bettendorf and Defendant Middle Road as the developers and Murphy who, by virtue of his purchase of Lot 3, Block 4, joined in the unilateral agreement of Defendant Bettendorf and Defendant Middle Road, who owned the said "P.U.D. Zoned" Planned Parenthood land in fee simple in 1975.

6. The City of Bettendorf is named as a Defendant because of its participation with Middle Road in the draftsmanship and approval of Paragraphs 3 and 11 of the Restrictive (burden) and Protective (benefit) Covenants as noted above and in that part of the Abstract for the Final Plat of Block 1 (see **Exhibit A-2** and **A-3** and **Exhibit D** to this Petition at pages **D-1** through **D-11**) which reads in part as follows with respect to Paragraphs 3 and 11:

"RESTRICTIVE AND PROTECTIVE COVENANTS

" MIDDLE ROAD INVESTORS, INC., an Iowa Corporation, hereby establish and declare the following restrictive and protective covenants to be applicable to the following described real estate located in Scott

County, Iowa, to-wit: All lots in Blocks 1 through 6 of The Planned Unit Development known as Quad City Technological Research Center, to the City of Bettendorf, Iowa, which plat is recorded as Document No. 5134-73 in the office of the Recorder of Scott County, Iowa:

" 1. No building . . . .

" . . . .

" 3. No obnoxious or offensive trade shall be carried on upon any lot nor shall anything be done thereon which may be or become an annoyance or nuisance to the other lot owners in said addition.

" . . . .

" 11. These restrictions shall be in force from the date of the Owner's Certificate to which it is an exhibit until January 1, 1993 or until such later date to which the same may be extended as hereinafter provided, and shall run with and be binding upon all lots in said addition, and every part thereof and shall be appurtenant to and for the benefit of all said lot owners. These restrictions shall be automatically extended for an additional ten-year period on January 1, 1993, and each ten year anniversary of said date unless a written instrument signed and acknowledged by the owners of a majority of all the lots in Quad City Technological Center shall prior to such date or anniversary be recorded with the Recorder of Scott County, Iowa, abrogating or modifying the same in whole or in part to the extent therein set forth. In determining the majority of said lot owners, each lot shall be entitled to one vote to be cast according to the will of a majority in interest of any co-owners having interest therein whether such majority is represented by a majority of the undivided

interests in an entire lot or ownership of the greater portion of a subdivided lot. A contract purchaser or life tenant of the legal title shall be deemed the owner. In all other respects, ownership shall refer to record owner ship of legal title." (Our emphasis.)

" 11. Invalidity, abandonment or waiver of any one or more of the same restrictions shall in no wise affect any of the other restrictions, which shall remain in full force and effect.

" 12. In the event any person who may at any time own or occupy any of the numbered lots, or part thereof, in said Addition should violate or threaten to violate any of these restrictions, said Middle Road Investors, Inc. its successors and assigns, and the owners from time to time of any of the numbered lots in said Quad City Technological Center shall have the right to proceed in any court of law or equity, by injunction or otherwise, to enforce performance and restrain violation, or pursue any other remedy to which it or they may be entitled and shall have the right to collect from the party or parties violating or threatening to violate the same, either jointly or severally, all damages, costs, expenses and counsel fees resulting from the violation thereof, or incurred in, or in connection with, said proceedings.

"Dated at Bettendorf, Iowa, this 3rd day of April, 1973.

Middle Road Investors, Inc.
By: Robert D. Danico, President
(Corporate Seal) By: C.J. Munson, Secretary"

7. Thereafter, Middle Road did not plat Block 5 and 6 as planned. Instead, on June 16, 1976 (5 month after the conveyance of Lot 3, Block 4 to Murphy), Defendant Middle Road, without Notice to Murphy, conveyed the Planned Parenthood property by a Warranty Deed to "Robert Versman

and Rose Versman, husband and wife, as tenants in common, and to their heirs and assigns." The legal document conveying the real estate, contains an asterisk and the typed instruction reading "subject to restrictive covenants recorded as document 5134-73 S.C. Iowa Rec. Off." which is initialed by Robert D. Danico as President and C.J. Munson, as Secretary of Middle Road, Inc. (see Document 10830-76 at **Exhibit E** to this Petition).

8. 10 years later, on December 23, 1986, Robert H Versman and Rose Versman conveyed an undivided 1/12 interest in the Planned Parenthood property to each of the following six persons (a total of 50%):

Kenneth J. Versman
Linda Jean Versman
Stuart J. Heller
Judith Lee Heller
Frederick J. Glassman
Frances Belle Glassman

(See Document 25349-86, recorded on December 31, 1986, at **Exhibit F** to this Petition which contains the typed instruction reading: "Subject to: 1. Easements, covenants and restrictions of record.")

9. On December 24, 1986, Robert H. Versman and Rose Versman conveyed an undivided 1/12 interest in the Planned Parenthood property to each of the following six persons (a total of 50%):

Kenneth J. Versman
Linda Jean Versman
Stuart J. Heller
Judith Lee Heller
Frederick J. Glassman
Frances Belle Glassman

(See Document 1735-87, recorded on January 28, 1987 at **Exhibit G** to this Petition which contains the typed instruction reading: "Subject To: Easements, covenants and restrictions of record" and "This Warranty Deed confirms the deed executed by the Grantors on December 23, 1986, . . . recorded in the Scott County Recorder's office as Document No. 25349-86 and ratifies and approves the conveyance of a total of one-half of the real property legally described in Exhibit A hereto").

10. On January 3, 1987, Robert H. Versman and Rose Versman conveyed an undivided 1/12 interest in the Planned Parenthood property to each of the following six persons (a total of 50%):

Kenneth J. Versman
Linda Jean Versman
Stuart J. Heller
Judith Lee Heller
Frederick J. Glassman
Frances Belle Glassman

(See Document 1736-87 recorded on January 28, 1987 at **Exhibit H** to this Petition which contains the typed instruction reading: "Subject to: Easements, covenants and restrictions of record" and "This Warranty Deed confirms the deed executed by the Grantors on Jan. 2, 1987 recorded in the Scott County Recorders office as Document 165-87 and ratifies and approves the conveyance of a total of one-half of the real property legally described in Exhibit A hereto.")

11. On April 14, 1997, Kenneth J. Versman and Linda Jean Versman, Husband and Wife, Stuart J. Heller and Judith Lee Heller, Husband and Wife, and Frederick J. Glassman and Frances Belle Glassman, Husband and Wife, conveyed by Warranty Deed the Planned Parenthood property to Planned Parenthood of Greater Iowa, Inc. or Planned Parenthood of Greater Iowa Foundation, Inc. (See Document 09482-97, dated April 14, 1997 and recorded April 24, 1997 at **Exhibit I** to this

Petition (last in order).

PETITIONER MURPHY'S CONTENTIONS

12. An actual controversy has arisen between Petitioner Murphy and Defendants, relating to the legal rights and duties of Defendant Planned Parenthood and Defendant Bettendorf, in respect to said Lots as those rights and duties are affected by Paragraph 3 and Paragraph 11 of the above stated Restrictive (burden) and Protective (benefit) Covenants. Petitioner Murphy contends that Paragraph 11 must be construed against its co-author Defendant Bettendorf and read to extend the Restrictive and Protective Covenants automatically for an additional, finite ten-year period on January 1, 1993 to January 1, 2003 without reference to that language which appears after the "comma" which follows the date "January 1, 1993". It would appear that such "finite" language was adopted to keep the first additional 10-year period extension in compliance with the requirements of **Bettendorf Code §614.24** which was enacted in 1966 and was interpreted by the Iowa Supreme Court in ***Compiano v. Kuntz***, 226 N.W.2d 245 (Iowa 1975) and ***Presbytery of Southeast Iowa v. Harris***, 226 N.W.2d 232, 237-38, 242 (Iowa 1975). Because the "finite" 10-year extension period was accomplished during the first 21-year period and was a recorded document, it met the requirements of **Bettendorf Code §614.24**, which then read "unless the claimant shall, by himself, or by his attorney or agent . . . . Shall file a verified claim with the recorder of the county wherein such real estate is located within said twenty-one year period".

13. Defendant Bettendorf is a **Home Rule** City in the State of Iowa which is empowered to enact zoning ordinances (i.e., P.U.D. and C-5 Zones) and amendments (zone changes) on real property in the City of Bettendorf, acting by and through the Bettendorf City Council, and to act as "parens patria" on behalf of Petitioner Murphy and other Bettendorf residents

(citizens) in defense of their property rights under such zoning ordinances when such zoning rights of the City of Bettendorf are challenged by third parties in a Federal District Court in a Federal Civil Rights action pursuant to **42 U.S.C. §1983**.

14. Such zoning ordinances and zone changes are accomplished by a legislative act by the City Council to accomplish the same. Under the **Doctrine of Separation of Powers**, the general rule is that the Courts cannot write or rewrite the zoning laws, nor force the legislative body to enact or amend a zoning ordinance. An amendment which is adopted in disregard of the protest of property owners who are acting pursuant to a valid "protest" ordinance, is void. The City of Bettendorf is a necessary party in that a Federal Judgment of U.S. District Court Judge Charles R. Wolle in a Federal Civil Rights action brought by Defendant Planned Parenthood, purports to rezone the Planned Parenthood property (P.U.D. Zone to C-5 Zone). Under the **Doctrine of Separation of Powers**, the general rule is that a federal court has no power (lack of subject matter jurisdiction) to rezone real property in the City of Bettendorf, which function (zoning), under the U.S. Supreme Court decision in ***Huffman v. Pursue, Ltd.***, infra., must be held to be both a "municipal affair" and an "important state matter" which is protected by the **11th Amendment**.

15. Defendant Planned Parenthood wishes to construct a clinic in Bettendorf, Iowa which will cater to the "abortion" trade. The **Bettendorf Zoning Ordinance** allows abortion clinics on property in a C-5 zone. Had Planned Parenthood purchased a C-5 Zoned property, it would not have had a zoning problem. Instead, it chose to purchase a property in a P.U.D. Zone (which was surrounded by and within 200 feet of three relatively new residential apartment complexes on Lots 1, 2, and 3 of Block 4 which were benefitted by a **Bettendorf "Protest" Ordinance**) and submitted an application for a Zone Change by ordinance to C-5.

16. The adjacent apartment owners (see **Exhibit C–**

Murphy and Jecklin) and Larry Whitty, the owner of Lot 1, Block 1 objected and made a successful statutory protest (**20% Rule**) against the zone change (being within 200 feet of the Planned Parenthood property), pursuant to **Bettendorf Zoning Code §24.2** and **§24.4**, which precluded the Bettendorf City Council from adopting a C-5 Zoning Ordinance unless the City Council voted 6-1 for the zone change. The City Council on March 16, 1996, voted 5-1 not to adopt the C-5 Zoning ordinance.

17. Zoning Rights are "**Vested Rights**" under Iowa Law and the **Iowa Constitution**. The 8th Circuit Court of Appeals has so held in its decision in ***Nemmers v. City of Dubuque, Iowa***, 716 F.2d 1194 (1983). Under Iowa case law, a City Council's action on a zone change request is broadly defined to be a "judicial function" which can be appealed by Writ of certiorari to the Iowa District Courts, see ***Montgomery v. Bremer County Board of Supervisors***, 299 N.W.2d 687 at 692 (Iowa Supreme Court 1980). If such an appeal is not filed within 30 days, the City Council's actions become final under Iowa law, in which case, under the **11th Amendment** and ***Huffman v. Pursue, Ltd.***, 420 U.S. 592 at 606, fn. 18 and 19 and the progeny of ***Huffman*** (***University of Tennessee v. Elliott***, 470 U.S. 788, 92 L.Ed.2d 635, 106 S.Ct. 3220 [1986], and ***Migra v. Warren City School Dist. Bd. of Ed.***, 465 U.S. 75, 70 L.Ed.2d 56, 104 S.Ct. 892 [1984], and ***Plough v. West Des Moines Community School District***, 70 F.3d 512 at 516-517 [CA 8th 1995]), the City Council's quasi-judicial order also becomes final and ***Res Judicata*** under Federal law, because the federal courts are required to give this ***Res Judicata*** **Rule** the same interpretation given it by the state court.

18. On March 21, 1997, one year and two days after the City Council's denial of the zoning change, Defendant Planned Parenthood filed a Civil Rights Action under **42 U.S.C. §1983** in the U.S. District Court (pleading what is, in essence, an appeal from the Bettendorf City Council's quasi-judicial Order denying the C-5 zoning Application). Planned

Parenthood did not name as defendants the adjacent apartment owners and Larry Whitty, who made the successful statutory protest.

19. The City of Bettendorf filed a Motion for a Partial Summary Judgment, pursuant to the **11th Amendment** and the ***Res Judicata*** **Doctrine**. U.S. District Judge Charles R. Wolle (egregiously) denied the city's ***Res Judicata*** Plea. Upon the conclusion of the Federal trial, Judge Wolle entered a judgment which purported to rezone the property to C-5 Zoning.

20. Petitioner Murphy timely moved to intervene (immediately after the City of Bettendorf announced its decision not to act as "***parens patria***" and pursue an appeal from the Judgment of U.S. District Court Judge Wolle), and within the appeal time period, for the purpose of appealing U.S. District Court Judge Wolle's Judgment on **11th Amendment** (lack of subject matter) jurisdictional and other grounds, including his denial of Bettendorf's Summary Judgement Motion on a plea of ***Res Judicata***.

21. U.S. District Court Judge Wolle ruled (cursorily and egregiously) on Petitioner Murphy's extensive pleadings: (1) that the Intervention Motion was "untimely", (2) refused to address the merits of Petitioner's right to mandatory intervention, and the **11th Amendment** Jurisdictional and ***Res Judicata*** issues raised by Murphy at the time of Murphy's Intervention Motion, and (3) further refused to set such matters for oral argument.

22. In the Court of Appeals below, Petitioner Murphy sought judicial relief from Judge Wolle's arrogation of Federal Judicial Power in two separate forms: by the filing of a direct appeal and by the filing of a verified complaint in an original Petition for Writ of Mandamus in the 8th Circuit Court of Appeals, pursuant to **28 U.S.C. §1651(a)**.

23. In a highly unorthodox ruling, the Court of Appeals treated the Appellant's Opening Brief on the direct appeal and the original petition for a prerogative writ of mandamus as though they had been consolidated, and in a brief single order, denied the Petition for Writ of Mandamus without an opinion and summarily affirmed Judge Wolle's Judgment, also without opinion. The Court of Appeals thereafter also denied a Petition for Rehearing and Suggestion for Rehearing En Banc in each of the two cases. The U.S. Supreme Court refused to issue its discretionary Writ of Certiorari to review such erroneous rulings.

24. Petitioner Murphy contends that the **11th Amendment** and the **Doctrines** of ***Res Judicata*** and ***Stare Decisis*** control this litigation and that both of the Federal Courts were in error in their refusal to address the issue of "lack of subject matter jurisdiction" of the Federal Courts under the **11th Amendment** claim. See ***Steel Co. v. Citizens for a Better Environment***, 523 U.S. 83, 140 L.Ed.2d 210, 118 S.Ct. 1003 (March 4, 1998), at **Point III** (duty to address the questions of subject matter jurisdiction as the first order of business, and on its own motion, if the parties to the lawsuit do not bring the matter to the trial court's attention); ***Puerto Rico Aqueduct and Sewer Authority v. Metcalf and Eddy, Inc.***, 121 L.Ed.2d 605 at 610, 506 U.S 139, 113 S.Ct. 684 (1993) (creating a new **Rule of Court** re the issue "lack of subject matter jurisdiction"), ***Wisconsin Dept. of Correction v. Schacht***, 524 U.S. ___, 141 L.Ed.2d 364 at 375-378, 118 S.Ct. ___, No. 97-461 (June 22, 1998) (Associate Justice Kennedy's concurring opinion re the issue of "lack of subject matter jurisdiction"). See ***Kerr v. U.S. District Court***, 426 U.S. 394, 48 L.Ed.2d 725, 96 S.Ct. 2119 (1976); ***Will v. U.S.***, 389 U.S 90, 19 L.Ed.2d 305, 88 S.Ct. 269 (1967); and **Supreme Court Practice**, 7th Ed., Stern, Gressman Shapiro, Geller, at page 495.

25. Plaintiff Murphy further contends: (1) that he is entitled to a Declaratory Judgment in the District Court of Iowa which holds that, under Iowa Law, the Bettendorf City

Council's action on the above zone change is a "judicial" function which became final when Defendant Planned Parenthood did not perfect an appeal to the Iowa District Court by Writ of Certiorari within 30 days of the date on which the City Council acted; (2) that the record shows that the adjacent apartment owners made a successful statutory protest which precluded the Bettendorf City Council from adopting a C-5 Zoning Ordinance unless the City Council voted 6-1 for the Zone Change, and that the City Council on March 19, 1996 voted 5-1 not to adopt the C-5 Zoning Ordinance; (3) that pursuant to such successful protest, the adjacent apartment owners acquired "**vested rights**" in the City Council's Final Order (judgment); and (4) that the City Council's final order which denied the C-5 Zoning Application was and is a final judgment which, under Iowa law and the **Constitutional Doctrine of *Res Judicata*** was and is entitled to recognition by the U.S. District Court, the 8TH Circuit Court of Appeals and the U.S. Supreme Court.

26. Murphy believes and avers that the Bettendorf City Attorney, Greg Jaeger, will acknowledge on behalf of the Defendant Bettendorf: (1) that the adjacent property owners did make a successful protest under the **Bettendorf "Protest" Ordinance**, which reads as follows:

> "24.4 In case the commission does not approve the proposal or in case of a protest against such change signed by twenty (20) percent or more of one or more of the following groups:
>
> " (a) Property owners of the lots included in such proposed change.
>
> " (b) Property owners immediately adjacent in the rear thereof extending the depth of one lot or not to exceed two hundred (200) feet therefrom (excluding street right-of-way).

" (c) Property owners immediately adjacent in the front thereof extending the depth of one lot or not to exceed two (200) feet therefrom (excluding street right-of-way).

" (d) Property owners immediately adjacent to any and all sides (including the front and rear sides) of the proposed change extending one lot or not to exceed two hundred (200) feet therefrom (excluding street right-of-way).

" Such amendment shall not become effective except by the favorable vote of at least three-fourths (3/4) of all the members of council.";

(2) that the **"Protest" Ordinance** is constitutionally valid and was validly applied; and (3) that the **Doctrine of *Res Judicata*** as pleaded by Defendant Bettendorf in the Federal Civil Rights lawsuit did, in fact, require that the Civil Rights action which was filed in the U.S. District Court be dismissed for lack of subject matter jurisdiction under the **11th Amendment** and ***Huffman***, supra.

27. Murphy further avers that, upon the successful termination of the Declaratory Judgment proceedings before this Court, Plaintiff intends to file a Declaratory Judgment Action in the U.S. District Court to have Judge Wolle's Judgment vacated on the ground that the Federal District Court lacked **Article 3, §2** subject matter jurisdiction under the **11th Amendment**, and the U.S. Supreme Court's ***Huffman*** **Abstention Doctrine**, ***Rooker-Feldman*** **Abstention Doctrine**, ***Res Judicata*** **Doctrine**, and the ***Stare Decisis*** **Doctrine**, and for other reasons which have been made of record in the U.S. District Court, the U.S. Court of Appeals for the 8th Circuit, and the U.S. Supreme Court; and if necessary, will petition the U.S. Supreme Court for a Writ of Certiorari on the **11th Amendment** issue and

Substantial Federal Questions which have been presented to the U.S. Supreme Court by the conflict in the determination of this issue by the State of Iowa and Federal Judiciary. See, in this regard, the copy of the pleadings on file in the U.S. Court of Appeals for the 8th Circuit and in the U.S. Supreme Court which are being lodged concurrently with the Clerk of this Court by Petitioner Murphy.

28. No other adequate remedy other than that herein prayed for exists by which the rights of the parties hereto may be determined; in that (1) U.S. District Court Judge Wolle has egregiously (willfully, knowingly and wrongfully) denied Petitioner Murphy's lawful right to intervene in the Federal Civil Rights action of Defendant Planned Parenthood, as an indispensable party; in order that he might appeal the (egregiously) erroneous judgment of Judge Wolle which created the opportunity for Planned Parenthood to engage in a course of conduct which constitutes a breach of **Bettendorf Zoning Code §24.2** and **§24.4** and Paragraph 3 of the Restrictive and Protective Covenants; (2) the Court of Appeals for the 8th Circuit refused to entertain Petitioner Murphy's appeal from Judge Wolle's erroneous judgment and a Petition for Writ of Mandate; and (3) the U.S. Supreme Court refused to exercise its discretionary review of the Federal Court record by Writ of Certiorari. Because Murphy was wrongfully denied the right to intervene in the Federal Civil Rights lawsuit, he is not bound by Judge Wolle's Judgment in the Civil Rights action under the **Doctrine of *Res Judicata***; see ***International Union v. Scofield*** 382 U.S. 205, 15 L.Ed.2d 272 (1965).

29. Murphy avers and contends that the Restrictive and Protective Covenants which were established by the Defendant Middle Road Investors, Inc. on April 3, 1973 at the time of the platting of Block 1 (see Petition at **Exhibit D-1** through **D-11**) and re-established and confirmed by the Defendant Middle Road Investors, Inc. on January 20, 1976 as the owner and proprietor of Lot 3 of Block 4, as set forth at **Exhibit A-2** and **A-3** to this Petition, run with the land and were

fully operational and binding on all parties during the period January 20, 1976 through January 1, 1993; and on that date were automatically extended for an additional ten year period from January 1, 1993 through January 1, 2003 by the provision of paragraph 11 of the Restrictive and Protective Covenants (see **Exhibit D-6** and **D-7**) and were and are presently operative and binding on all parties, including the Defendant Planned Parenthood of Greater Iowa, Inc. from and after April 14, 1997, when Planned Parenthood received title to such property by Warranty Deed from Kenneth J. Versman, etc. (see Petition at paragraph 11 on page 6 of the Petition and Document 09482-97, dated April 14, 1997 and recorded April 24, 1997 at **Exhibit I** to this Petition [last in order]).

30. Defendant Planned Parenthood's projected use of such property in the face of the successful protest of the Bettendorf residents adjoining such property under **Bettendorf "Protest" Zoning Code §24.2** and **§24.4** constitutes an immediate and continuing breach of Paragraph 3 of the Restrictive and Protective Covenants which requires that "No obnoxious or offensive trade shall be carried on upon any lot nor shall anything be done thereon which may be, or become, an annoyance or nuisance to the other lot owners in said addition." (Our emphasis.)

31. Petitioner has no adequate remedy at law to compensate for the harm to the reputation and contemporary community standards of the City of Bettendorf, Iowa which flows from the knowledge of the general public that land in Bettendorf, Iowa, a Home Rule City, which is adjacent and within 200 feet of an existing residential neighborhood is being used for the conduct of early abortions, late term abortions, and partial birth abortions also known and referred to as "infanticide". Under these facts and circumstances, and upon this record, Defendant Planned Parenthood must be held to be engaged in a trade which is "obnoxious" and "offensive" as a matter of law under the terms of paragraph 3 of the Restrictive and Protective Covenants (see **Exhibit D-5** to this Petition); and

is both a public and private nuisance under the **English Common Law**, the early **American Common Law**, the **Statutes of the State of Iowa** and the **"Protest" Zoning Code, §24.2** and **§24.4** of the City of Bettendorf. The Defendant's continuous breach of said Covenant and maintenance of a public and private nuisance will result in irreparable harm to the value of Petitioner's land and the pecuniary amount of such damage, which is impossible to ascertain, warrants the issuance of a preliminary injunction.

QUESTIONS PRESENTED FOR THE IOWA DISTRICT COURT ON THIS PETITION FOR A DECLARATORY JUDGMENT.

1. Whether **Bettendorf Zoning Code §24.2** and **§24.4** are constitutional on their face?

2. Whether the order of the Bettendorf City Council which denied the Planned Parenthood Zone Change Application from P.U.D. to C-5 zoning by a 5-1 vote is ***Res Judicata*** under Iowa law because Planned Parenthood did not timely appeal such order to the Iowa District Court by Writ of Certiorari?

3. Whether that part of the record which shows that three of the adjacent property owners (Clarence Murphy [Petitioner], owner of Lot 3, Block 4, Lois Jecklin, owner of Lots 1 and 2 of Block 4, and Larry Whitty, owner of Lot 1, Block 1) made a successful statutory protest under **Bettendorf Zoning Code §24.2** and **§24.4**, mandates a ruling by this Court that the zoning on the Planned Parenthood property under Iowa law is "P.U.D." and remains as "P.U.D."?

CONCLUSION

The complex propositions of Iowa Zoning law which are framed by this Petition provide irrefutable, positive proof:

(1) that legal issues involving the zoning laws of a state are "important state matters" which are protected by the **11th Amendment** and the ***Huffman*** **Abstention Doctrine**, and (2) that a U.S. District Judge lacks "subject matter jurisdiction" of such issues which, according to the laws of probability, will be decided differently for each state based upon the Judicial Policy of the state which is affected. The U.S. Supreme Court has held in the ***Huffman*** cases that, pursuant to the ***Res Judicata*** **Doctrine**, the U.S. District Court must extend to such State Court judgments the interpretation given by the State Court Judiciary (the equivalent of the "**Full Faith and Credit**" provision of the **Federal Constitution** which governs the responsibility of the Judiciary of State Courts to acknowledge the judgments of the Judiciary of other State Courts).

WHEREFORE, Petitioner prays that judgment be entered against the Defendants:

1. For a Declaration, pursuant to Iowa Law, that the Bettendorf City Council's action on Planned Parenthood's Zone Change Application from PUD to C-5 Zoning is a judicial function which became final when Defendant Planned Parenthood did not perfect an appeal to the Iowa District Court by Writ of Certiorari within 30 days of the date on which the City Council acted on such Application; that the record shows that the **"Protest" Ordinance** is constitutional and was applied in a constitutional manner; that pursuant to said successful protest, the adjacent property owners acquired "**vested rights**" in the City Council's Final Order (judgment); that the City Council's denial of the C-5 Zoning Application, under the constitutional **Doctrine of *Res Judicata*** is a Final Judgment and that the Zoning on the Planned Parenthood property under Iowa law is "P.U.D." as enacted by the Bettendorf City Council.

2. That during the pendency of this action, a preliminary injunction issue to enjoin and restrain the Defendant Planned Parenthood from the acts and conduct aforesaid.

3. That the Defendant Planned Parenthood be restrained and enjoined from violating and continuing to violate and breach **Bettendorf "Protest" Ordinance §24.2** and **§24.4** and Paragraph 3 of the Protective Covenants that runs with Lot 3 of Block 4 during the time the same is to remain in force and effect;

4. For costs, and attorneys fees and other relief as provided above; and

5. For such other and further relief as the Court may deem proper.

DATED: January ___, 2000

Respectfully submitted,

_____

Clarence J. Murphy, Plaintiff

VERIFICATION

State of California)
} SS:
Los Angeles County)

Declaration under Penalty of Perjury, Pursuant To California Code of Civil Procedure §2015.5

I am the attorney for Plaintiff Clarence J. Murphy and as such attorney, the facts as pleaded in the above Petition are more fully known to me. I therefore make this Declaration and declare under penalty of perjury under the laws of California that the forgoing **First Amended Petition for a Declaratory Judgment and an Injunction** is true and correct.

Dated: January 31, 2000
Location: 9055 La Tuna Canyon Road
La Tuna Canyon, California 91352-2221

/S/

James J. Clancy, California Bar No. 26946
9055 La Tuna Canyon Road
La Tuna Canyon, California 91352-2221
(818) 352-2069 Fax: (818) 352-6549

Attorney for Petitioner Clarence J. Murphy

APPENDIX D

LAW ENFORCEMENT *MEMORANDUM* OF AMICUS CURIAE JAMES J. CLANCY, DATED NOVEMBER 24, 1999, DOCUMENTING PAST HISTORICAL EVENTS, DISASTROUS RESULTS, CONFUSION AND SERIOUS DETRIMENT SUFFERED BY THE GENERAL PUBLIC AS A RESULT OF THE INTERFERENCE OF THE FEDERAL COURTS WITH THE 10TH AND 11TH AMENDMENT SOVEREIGN POWER OF THE INDIVIDUAL STATES TO REGULATE THE COMMERCIAL SALE, DISTRIBUTION, ETC., OF HARD-CORE PORNOGRAPHY BY CLOSURE OF THE PREMISES AS A COMMON LAW PUBLIC NUISANCE, AS EXEMPLIFIED BY THE U.S. SUPREME COURT'S DECISION IN *HUFFMAN V. PURSUE, LTD.*, 420 U.S. 592, 43 L.ED.2D 482, 95 S.CT. 1200 (1975), REH. DEN., 421 U.S. 971, 44 L.ED.2D 463, 95 S.CT. 1969.

(Reference: *Brief Amicus Curiae of James J. Clancy, etc.*, ...Page 14, lines 12-13,
..... Page 18, footnote 4,
..... Page 24, line 24,
..... Page 25, lines 4, 8.)

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(818) 352-2069
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November 24, 1999

MEMORANDUM

SUBJECT:

1. ***Los Angeles Times*** news article, dated September 1, 1999, with headline reading "L.A. Economy's Dirty Secret: Porn Is Thriving"; and

2. Mayor Richard Reardon's response to the press that he "wishes the industry was headquartered somewhere else" and that he is "ashamed of the porno industry".

3. **(a)** The use of Orange County Superior Court Exhibits (records) in the form of autoptical proferences (time and motion studies of pornographic films to establish visual proof of Justice Potter Stewart's "phenomenon" [1/] that one knows hard-core pornography when he sees it), and **(b)** the use of 11 years of public nuisance abatement adjudications in Santa Ana (1975-1986) (pursuant to which such pornographic films were declared to be hard-core pornography and enjoined by Order of Court) to prove, by example and similitude, the existence of identical moral public nuisances and unlawful business practices in the San Fernando Valley, ***(Excised Line)***.

[1/] Phenomenon is defined in Webster's Collegiate Dictionary, 5TH Edition, as "any object known through the senses rather than thought or intuition; specifically with Kant, the object of experience.

4. My contention that "closure" is mandated where the visual evidence which is offered is in the form of autoptical proferences; i.e., time and motion studies of films which provide irrefutable proof of hard-core pornography as the sole stock in trade, which is both a common law public nuisance under ***People ex rel. Busch v. Projection Room Theater***, 16 Cal.3d 350 [Mar. 4, 1976], as modified in 17 Cal.3d 42, 130 Cal.Rptr. 328, 550 P.2d 600 [June 1, 1976] and a statutory unlawful business practice under **Business and Profession Code §17200** and ***People v. E.W.A.P., Inc.***, 106 Cal.App.3d 315, 165 Cal.Rptr. 73 (CA2, dv5, 5-29-80) (hearing denied by Cal. Sup. Ct. on Aug. 21, 1980) which can be terminated by a lawsuit brought "by any person acting for the interests of itself, its members or the general public" (my emphasis). **Business and Professions Code §17.204**.

Pursuant to our phone conversation on October 28, 1999, I am personally delivering this Memorandum with its supporting documents, which will corroborate my representations in our September 1, 1999 and October 28, 1999 phone conversations that the present operations of the producers and distributers of "Porno" films and videotapes in the San Fernando Valley can be stopped through legal process.

Both the September 1, 1999 ***Los Angeles Times*** news article (see copy at **Exhibit A** to this Memorandum) and Mayor Reardon's remarks acknowledge that the production and distribution of obscene motion picture films and videotapes is rampant in the City of Los Angeles. The Mayor's remarks imply that there is nothing that the Mayor can do to stop that activity. I do not agree. The Orange County Superior Court records as to the number of injunctions which were issued in 11 years of Public Nuisance Abatement litigation, establish that the contrary proposition is true.

Upon reading the September 1, 1999 ***Los Angeles***

Times news article, I immediately picked up the phone and called to see if it would be possible for you to "access" the Mayor and alert him to the facts **(1)** that he has not been fully advised; and **(2)** that the production and distribution of such pornographic films can be stopped by the use of legal process by any person, pursuant to the **Business and Professions Code**. I stated that if a foundation grant were made available for such purposes, I could, within a relatively short period, prepare and submit a comprehensive study and report ***(Excised Line)*** based upon my 11 years of personal experiences with litigation in Santa Ana, with full documentation by way of autoptical proferences; that is, time and motion studies", which would establish: **(1)** that the production and distribution of such pornographic films and videotapes, identical to those in the litigation in Santa Ana, is both an unlawful business practice and a public nuisance in Los Angeles, and **(2)** that such unlawful business can now be closed down by an Equity Decree under the **Federal Constitution** pursuant to the **11TH Amendment** Sovereign Powers of State Judiciaries to act upon important State matters, and that the proposed Study would outline the steps that need to be taken in the Courtroom to achieve that objective.

(Excised Paragraphs [2][suggested remedy]).

As background, I performed legal services for the City Council of Santa Ana during the 11 year period 1975-1986 in a monumental effort by the City of Santa Ana to close the Mitchell Brothers' Santa Ana Theatre in Honer Plaza (formerly a United Artist's Family Theater) as a moral public nuisance. Unfortunately, at that time, the membership of the U.S. Supreme Court was badly "fragmented" and it was impossible to get the members of the High Court to note jurisdiction and rule on the constitutionality of the "closure" issue. I believe that had we been able to "force" a ruling out of the U.S. Supreme Court, we would have been able to achieve our Orange County objective in Santa Ana and close the Theatre, based upon past illegal conduct, and the problems that

exist today would not have developed.

In the interim 13 years, the balance of power on the High Court has shifted, and that objective can now be achieved, due to the new interpretation recently given to the **11TH Amendment** powers by a majority of five members on the present Court (Rhenquist, Kennedy, Scalia, Thomas and O'Connor) regarding "state sovereignty" and the subject matter jurisdiction of the state judiciary as to important state matters pursuant to the **11TH Amendment**. The recent interest in the **11TH Amendment** as a viable theory regarding state power, gives states new latitude in crafting, and implementing innovative solutions to state law enforcement problems.

In the first four years, (Sep. 1975 - Jun. 21, 1979) of our eleven year Santa Ana operations (1975-1986), the City of Santa Ana surveilled two pornographic films each week and did a comprehensive analysis of the same by the construction of "time and motion studies" and "continuities", as evidence in the form of "autoptical proferences". A list of those films which were named in four public nuisance abatement lawsuits is enclosed with this memo as an appendix to my Status Report to the Santa Ana City Attorney, dated October 28, 1982. See, also, my Status Report to the Santa Ana City Attorney, dated March 24, 1980, at page 5, which identifies four public nuisance abatement lawsuits and the number of pornographic films in each lawsuit as follows:

Lawsuit	Case No.	Period Covered
(Gow I)	25-65-30 (filed Nov. 2, 1976)	October 1975 - April 13, 1977 (24 Programs, 48 films)

Lawsuit	Case No.	Period Covered
(Gow II)	28-12-14 (filed Dec. 20, 1977)	April 13, 1977 - October 19, 1977 (12 Programs, 24 films)

(Gow III)	29-91-83 (filed Oct. 3, 1978)	July 15, 1978 - November 2, 1978 (13 Programs, 26 films)
(Gow IV)	31-55-93 (filed June 21, 1979)	November 2, 1978 - January, 1979 and April, 1979 - August, 1979 (23 Programs, 42 films)

144 Films

The Courtroom litigation during the period 1976-1979 described above involved the defense of one Federal copyright and one Federal Civil Rights lawsuit, and the prosecution of four State Court Public Nuisance Abatement lawsuits in which all 144 pornographic films were adjudicated at hearings on Motions for Preliminary Injunction, to be hard-core pornography and enjoined by the Orange County Superior Court as Common Law Public Nuisances, in violation of the California Obscenity Statutes. Those Superior Court deliberations were affirmed by the Court of Appeal and review was denied by the California Supreme Court. To this date, those adjudications have not been reversed. See, in this regard, the two bound volumes which are enclosed containing copies of the following Eight (8) Status Reports to the Santa Ana City Attorney dated:

April 24, 1979; December 14, 1979; March 24, 1980; May 12, 1980; December 12, 1980; December 31, 1981; October 28, 1982; and June 23, 1986; and other letters.

Thirteen (13) years later, resistance to the dissemination of such hard-core pornographic videotapes has virtually collapsed. I am enclosing a copy of a pornographic publication (3/4" thick, containing 350 pages), which is published every January and distributed by the Porno Industry in Los Angeles and elsewhere in the U.S., under the title "Adult Video News" (A.V.N.) and "Adult Entertainment Guide", "broadcasting" the

hard-core pornographic film titles which are now available in Los Angeles, the identity of the L.A. Producers, and Distributors of such pornographic films, the names of the actors and actresses and the nature of the hard-core pornographic content.

The remarkable part of this change in law enforcement efforts is that almost everyone of the pornographic films which were surveilled in Santa Ana during that 11-year period is named in the A.V.N. Adult Entertainment Guide. See and compare, in this regard, the titles listed in my Status Report to the Santa Ana City Attorney, dated October 28, 1982 (at "Appendix H"), and pages 204-207 of the A.V.N. Adult Entertainment Guide, listing the video titles of the hard-core pornographic "classics" which are available, with a check mark as to those titles which were exhibited and surveilled at the Mitchell Brothers' Theatre during the period October, 1975 - August, 1979 (see copy at **Exhibit B** to this Memorandum), which were the subjects of the Public Nuisance Abatement lawsuits known as Gow I, Gow II, Gow III and Gow IV and enjoined by the Orange County Superior Court as unlawful hard-core pornography, and upheld by the California Court of Appeal and California Supreme Court !

The magazine itself is pornographic. Further, all of the pornographic films listed therein which were held to be hard-core pornography by the Orange County Superior Court are products of an unlawful business practice and subject to abatement in Los Angeles County as public nuisances as a matter of law. To reach this conclusion , ***(Excised Words)*** need only examine the "autoptical proference" (time and motion study) for each of such films which is under challenge. The City of Santa Ana would not have been able to continue to maintain such lawsuits in the California Courts for 11 successive years without the "time and motion" studies to rely upon, and keep the City of Santa Ana in the courtroom. Such "autoptical proferences" are irrefutable.

I am transmitting two bound volumes of my correspondence and status reports to the Santa Ana City Attorney for the year 1979 and the years 1980 through 1986, on the progress of the Santa Ana lawsuits, containing my analysis of **(1)** the results achieved in the State and Federal Courts as to each of the above pornographic films and videotapes; **(2)** the nuisance abatement process (which was upheld by the California Supreme Court in ***People ex rel. Busch v. Projection Room Theater***, supra) (see copy at **Exhibit C** to this Memorandum); **(3)** the use of that process by seven other States (Washington, Ohio, Idaho, Georgia, Alabama, Texas and North Carolina); and **(4)** the news accounts of the closing down of the Exxxtasy and Tuxedo Channels on Satellite T.V. by Montgomery, Alabama District Attorney Jimmy Evans in December, 1990, using the "time and motion" and "continuity" studies which our operations prepared in Los Angeles with respect to the pornographic films (which included "The Opening of Misty Beethoven") which were exhibited by the Exxxtasy and Tuxedo Channels via Satellite and broadcast to Montgomery, Alabama and Los Angeles, California, simultaneously (see copy of the correspondence and news accounts of the demise of the Exxxtasy and Tuxedo Channels at **Exhibit D** to this Memorandum).

Each of the pornographic films which were named in those Santa Ana lawsuits was supported by a "time and motion study" which was examined by the City Council Members prior to their voting to authorize a public nuisance abatement lawsuit to be filed on such films. See my letter to the City Attorney, dated May 11, 1979. This was the "key" to our success in the Courtroom. The use of the "time and motion study", as autoptical evidence ("I know it when I see it" "phenomenon"—with no need to apply a definition and the "reasoning" mind) precluded the Mitchell Brothers from making the obscenity definition an issue or turning the lawsuit into a semantical debate. The Mitchell Brothers candidly admitted in their depositions that they produced and exhibited only hard-core pornography. It would have been impossible for them to argue

a plausible contrary proposition or come to a plausible contrary conclusion. For obvious reasons, no injunction was sought by the City of Santa Ana prior to a judicial determination on the merits.

Regretfully, on November 30, 1981, the U.S. Supreme Court refused to grant a hearing on the "closure" issue we had drawn in our primary lawsuit (Gow I). That issue was squarely before the High Court twice on the Santa Ana City ***Petitions for a Writ of Certiorari*** in Case No. 81-271 and Case No. 82-345 (see copy of "Reasons for Granting Review" in 82-345 at **Exhibit E** to this Memorandum). It took that long (5 years) to frame the "closure" issue at trial and get Case No. 81-271 before the High Court on appeal. We did this by getting the Trial Judge to make a finding of fact that he would have closed down the Theatre because of the contents being exhibited (which he described in detail) if the Constitution permitted him to do so under the U.S. Supreme Court decisions. See Status Reports, dated December 31, 1981, at pages 3-4, and October 28, 1982 at pages 1-2. Instead of ruling on the "closure" issue in Case No. 81-271, the U.S. Supreme Court reversed on the burden of proof issue summarily and without briefing or oral arguments, holding that in a civil case, the Equity"clear and convincing" burden of proof was satisfactory, and that the criminal standard of "beyond a reasonable doubt" was not applicable. This posed a real problem for Santa Ana, because the California Supreme Court in ***People ex rel. Busch v. Projection Room Theater***, supra, had refused to consider the "closure" issue on appeal, absent a decision from the U.S. Supreme Court on the "closure" issue. See Associate Justice Clark, concurring and dissenting in ***People ex rel Busch***, 17 Cal.3d 42 at page 62 (see copy of the ***Busch*** decision at **Exhibit C** to this Memorandum).

In the meantime, a coordinated effort was made to get the "closure" issue before the High Court in one of the seven other State cases, which were pursuing the same remedy (Washington, Ohio, Idaho, Georgia, Alabama, Texas and North

Carolina). Those efforts were also unsuccessful.

In ***State of Idaho, ex rel. Kidwell, Attorney General and Leroy, Ada County Prosecuting Attorney v. U.S. Marketing, Inc., et al.***, ___ Idaho ___, 631 P.2d 622 (March 29, 1981), the Idaho Supreme Court reversed the trial court and held that closure was constitutional and authorized the award of attorney fees (see copy of ***State of Idaho, ex rel. Kidwell and Leroy*** at **Exhibit C** to this Memorandum). Upon appeal, the U.S. Supreme Court first noted jurisdiction of those issues, and then vacated that ruling when ***U.S. Marketing, Inc, et al.*** withdrew its appeal voluntarily so as not to have the High Court rule on and uphold the closure issue. ***U.S. Marketing, Inc, et al.*** was ordered to do so by the suppliers who did not want a ruling on that issue. See Status Report, dated December 31, 1981. See also, pages 32-65 at page 36 of the ***Petition for Writ of Certiorari*** in ***Edward Cooper, City Attorney of Santa Ana v. Mitchell Brothers' Santa Ana Theatre, et al.***, No. 82-345, October Term, 1982, which is attached to this Memorandum as **Exhibit E**.

The State case (on lack of subject matter jurisdiction) that came closest to solving Santa Ana's problem with the closure issue (***Carol Vance, et al. v. Universal Amusement Company, Inc., et al.***, No. 78-1588, U.S. Supreme Court, 1978 October Term, 455 U.S. 308 (1978) (involving state sovereignty, the **11TH Amendment** right of the state judiciary to apply the state statute to important state matters, and the issue of the Federal District Court's "lack of subject matter jurisdiction) was lost by a 5 to 4 decision when Texas Deputy Attorney General Lonny Zwiener gave the wrong answer to Associate Justice Stevens' questioning during oral argument. See my letter to Lonnie Zwiener, dated March 24, 1980. The City of Santa Ana filed an ***Amicus Curiae*** Brief in which it argued that the State of Texas had the right to exclude federal jurisdiction, pending a definitive ruling by the State High Court on the Texas Public Nuisance Statute. During oral argument, Deputy Attorney General Zwiener, without understanding the

consequences, innocently volunteered an incorrect statement that the State of Texas did, in fact, employ an interpretation that Justice Stevens felt was flawed. This error at oral argument cost the State the loss of Justice Stevens as a fifth vote, and the High Court's ruling upon the merits of the case, because Zwiener's "concession" during oral argument (which was not a part of the record), in effect, conceded "jurisdiction" and scuttled Santa Ana's ***Amicus Curiae*** argument and claim that the Courts of the State of Texas had not yet ruled definitively on such matters. The State of Texas Petitions had not raised or relied upon the "lack of subject matter" jurisdiction defense, but the Santa Ana ***Amicus*** brief had made it a defense which I was to argue, had Texas been able to arrange time for ***Amicus Curiae*** to argue. The High Court, however, denied Zweiner's motion that he be allowed to split his argument.

After ***Vance***, supra, it became apparent that the "closure" issue would not be ruled upon by the U.S. Supreme Court, absent a second appeal by Santa Ana in one of its later cases (which would have taken years to get the "closure" issue back to the High Court). The City of Santa Ana changed its procedure and started filing a separate action for each new weekly program. This also failed because the Presiding Judge would not give such trials the necessary "priority" and assign a courtroom to try the final injunction issue on a weekly basis. See Status Report to the Santa Ana City Attorney, dated June 23, 1986, at pages 1-6.

Because the High Court would not rule on the "closure" issue and the Santa Ana Superior Court would not assign a Court to try each case weekly on the final injunction, City Attorney Ed Cooper (who had replaced City Attorney Gow) abandoned the courtroom attempt to close down the Theatre by legal action in the courtroom and recommended it be done by eminent domain, incident to a plan of the City to upgrade the area by redevelopment.

In retrospect, it is now apparent that had Assistant

Deputy Attorney General Lonny Zweiner argued the "lack of subject matter jurisdiction" in 1982, the ***Vance*** case would have been decided differently and the "closure" issue could have been "forced" upon the U.S. Supreme Court for adjudication in the City's second ***Petition for Writ of Certiorari*** in No. 82-345, which was filed on August 24, 1982.

Today, because of the change in membership of the High Court, and the adoption of a new Court Rule in ***Puerto Rico Aqueduct and Sewer Authority v. Metcalf & Eddy, Inc.***, 506 U.S. 139, 121 L.Ed.2d 605, 113 S.Ct. 684 (1993) (which permits the **11TH Amendment** issue of "lack of subject matter jurisdiction" of the Federal District Court to be addressed at the commencement of the lawsuit in a pre-trial interlocutory appeal), the defect in the Santa Ana procedures can now be avoided. All that need be done is to apply for "closure" under the public nuisance abatement statutes and, assuming that the defendants remove that issue to the Federal District Court or that they file a Civil Rights action in the Federal District Court based upon the closure remedy, to immediately take an interlocutory appeal (pursuant to ***Puerto Rico Aqueduct and Sewer Authority***, supra, with respect to the federal interference, and the **11TH Amendment**) on the "closure" issue up to the U.S. Supreme Court.

(Excised Paragraph [suggested remedy]).

(Excised lines [suggested remedy]). My Status Report letters to the Santa Ana City Attorney are sequential, comprehensive, "instructive" and accurately state my position which is as valid now as it was in 1979. ***(Excised lines [suggested remedy])***.

(Excised Paragraphs [2] [suggested remedy]).

Inclusion of both the text of my letters and the synopsis "style" have special purposes. Both provide a different degree of proof, each of which is needed to forestall the customary

defensive "red herring" arguments and to maximize the probability that the judgment against the Porn Industry will prevail (buttressed by the use of a fully comprehensive report and autoptical evidence to "authenticate" the "summarized" statements of the law").

The federal court's "lack of subject matter jurisdiction" issue under the **11TH Amendment** which I attempted to get Lonny Zweiner to address as his primary issue, is at the very heart of this solution. No one understands that issue and its sand traps and pitfalls as I do, because of my 25 years of involvement with the **11TH Amendment** issue in the intervening years which have followed the argument in the U.S. Supreme Court in ***Huffman v. Pursue, Ltd.***, 420 U.S. 592, 43 L.Ed.2d 482, 95 S.Ct. 1200 (1975), reh. den., 421 U.S. 971, 44 L.Ed.2d 463, 95 S.Ct. 1969.

In my 1979-1980 letters I suggested that we are really involved in a "moral Dunkirk" of our own making. Support for that "concept" can be found in the November 10, 1999 ***L.A. Times*** news article, a copy of which is attached to this letter at **Exhibit A**, involving the staging of a Pornographic "Trade Show" in 1998 at Cal State Northridge.

I am unwilling to admit that our Judaeo-Christian community standards cannot be "recaptured" and "reinstated". All that need be done is for enough of the "good" people to do that which is needed to restore what is the absolute "truth" under the Natural Law, and to require that the necessary adjustment be made to the law which, presently, is grossly misinterpreted and misunderstood by our "younger generation".

APPENDIX E

OPINION OF CHIEF JUSTICE WARREN BURGER, WITH WHOM JUSTICE POWELL AND JUSTICE REHNQUIST JOIN, DISSENTING IN *BROCKETT V. SPOKANE ARCADES, INC.*, NO. 80-1604, 454 U.S. 1022, 70 L.ED.2D 468, 102 S.CT. 557 (1981).

(Reference: *Brief Amicus Curiae of James J. Clancy, etc.*, ...Page 26, line 4.)

MEMORANDUM CASES

No. 80-1604. Donald C. Brockett, etc., Appellant v Spokane Arcades, Inc., et al.

454 US 1022, 70 L Ed 2d 468, 102 S Ct 557.

November 9, 1981. Appeal from the United States Court of Appeals for the Ninth Circuit. The judgment is affirmed. Dissenting opinion by the Chief Justice with whom Justice Powell and Justice Rehnquist join.

Same case below, 631 F2d 135.

Chief Justice Burger, with whom Justice Powell and Justice Rehnquist join, dissenting.

The Court today affirms a decision of the Court of Appeals holding unconstitutional a Washington statute which has yet either to be enforced in or construed by a Washington state court. I would abstain from decision until the Washington courts are given an opportunity to interpret the law which has been thus invalidated. This Court—and all federal courts—have enough to do without "pre-empting" state courts on matters initially of state concern.

The Washington "moral nuisance" law, Wash Rev Code § 7.48.050 et seq. (Supp 1977) —a comprehensive statute directed at prohibiting the public sale and exhibition of obscene materials—was adopted as an initiative by the voters in the November 8, 1977, election. Before the statute was even certified by the Secretary of State, appellees, several corporations engaged in the exhibition, distribution, and sale of movies, books, and magazines, filed this action in the Federal District Court. On February 6, 1978, less than three months after the initiative's adoption, and apparently before it had ever been applied, the District Court declared the law unconstitutional. 449 F Supp 1145.

I have previously outlined the concerns that should lead a federal court to stay its hand in cases such as this, when litigants have deliberately avoided resort to the courts of the state whose statute is being challenged. Vance v Universal Amusement Co. 445 US 308, 317-320, 63 L Ed 2d 413, 100 S Ct 1156 (1980) (Burger, C. J., dissenting); cf. Moore v East Cleveland, 431 US 494, 521-531, 52 L Ed 2d 531, 97 S Ct 1932 (1977) (Burger, C. J., dissenting); Wisconsin v Constantineau, 400 US 433, 439-443, 27 L Ed 2d 515, 91 S Ct 507 (1971) (Burger, C. J., dissenting). The policies of federalism and comity militate in favor of affording state judges—who are as capable as are federal judges of enforcing the Constitution of the United States, and have taken the same oath to do so—the initial opportunity to consider the scope and validity of state statutes. This is particularly so when the state law under consideration has never been applied, and when its interpretation is uncertain; in such a case the state court's construction of the statute may obviate the need for adjudication of the federal constitutional issues, or the state court may resolve those issues as we would. Harrison v NAACP, 360 US 167, 3 L Ed 2d 1152, 79 S Ct 1025 (1959); City of Meridian v Southern Bell Tel. & Tel. Co. 358 US 639, 3 L Ed 2d 562, 79 S Ct 455 (1959); Railroad Comm'n v Pullman Co. 312 US 496, 85 L Ed 971, 61 S Ct 643 (1941).

Here, the Court of Appeals invalidated portions of the nuisance law dealing with the issuance of temporary and permanent injunctions against establishments exhibiting "lewd" or "obscene" matter, on the grounds that, inter alia, (1) "[n]o limits are set forth in the statute to confine the discretion of the court to issue the temporary abatement injunction," 631 F2d 135, 138 (CA9 1980); (2) "there is no assurance that there will occur the required prompt final judicial determination on the merits," ibid.; and (3) "a defense of nonobscenity *presumably* is unavailable at a trial for violation of an injunction" (emphasis added), ibid. Even a cursory examination of the lengthy statute—which contains detailed definitions of "lewd" or "obscene" matter incorporating the standards of Miller v California, 413 US 15, 37 L Ed 2d 419, 93 S Ct 2607 (1973), which provides for consolidation of the trial on the merits with the hearing on the temporary injunction and grants scheduling priority to cases brought under the statute, and which does not specify the defenses available in contempt proceedings—discloses that the state courts might well have construed the law so as to avoid each of these perceived deficiencies. It is ironic that, having exhibited no hesitation to construe the many provisions

of this complex statute without guidance from the state courts, the Court of Appeals wholly ignored an explicit severability clause and "declined" to preserve those parts of the statute *not* found unconstitutional, demurring that the reconstruction required to salvage the statute would be better handled by "the legislature of the State of Washington." 631 F2d, at 139.

In sum, both the District Court and the Court of Appeals should have declined to act until the parties had exhausted available state remedies, at least absent a showing that resort to the state courts would have been futile. There was no need whatever for federal courts to render a declaratory judgment as to the validity of a state law on which the state courts have not yet had an opportunity to speak and on behalf of parties against whom the law has not yet been applied. I would reverse and remand with directions to do now what should have been done initially.

No. 81-186. James A. McClure, United States Senator, Appellant v Ronald Reagan, President of the United States and Abner J. Mikva

454 US 1025, 70 L Ed 2d 469, 102 S Ct 559.

November 9, 1981. Appeal from the United States District Court for the District of Idaho. The judgment is affirmed. Justice Rehnquist took no part in the consideration or decision of this case.

Same case below, 513 F Supp 265.

No. 81-477. Donald M. Witte, Appellant v Bar Committee of the Twenty-First Judicial Circuit, etc.

454 US 1025, 70 L Ed 2d 469, 102 S Ct 559.

November 9, 1981. Appeal from the Supreme Court of Missouri. The appeal is dismissed for want of jurisdiction. Treating the papers whereon the appeal was taken as a petition for writ of certiorari, certiorari is denied.

Same case below, 615 SW2d 421.

No. 81-5422. William J. Crane, Appellant v B. Ross, et al.

454 US 1025, 70 L Ed 2d 469, 102 S Ct 559.

November 9, 1981. Appeal from the United States Court of Appeals for the Seventh Circuit. The appeal is dismissed for want of jurisdiction. Treating the papers whereon the appeal was taken as a petition for writ of certiorari, certiorari is denied.

Same case below, 645 F2d 78.

No. 81-478. Stephen D. Rabideau, Appellant v Attorneys Board of Professional Responsibility of Wisconsin

454 US 1025, 70 L Ed 2d 469, 102 S Ct 559.

November 9, 1981. Appeal from the Supreme Court of Wisconsin. The appeal is dismissed for want of a substantial federal question.

Same case below, 102 Wis 2d 16, 306 NW2d 1.

No. 81-524. Irene Johnson, as surviving spouse of Chester Johnson, Appellant v Kerr-McGee Oil Industries, Inc.

454 US 1025, 70 L Ed 2d 469, 102 S Ct 560.

November 9, 1981. Appeal from the Court of Appeals of Arizona, Division Two. The appeal is dismissed for want of a substantial federal question.

Same case below, 129 Ariz 393, 631 P2d 548.

APPENDIX F

OPINION OF JUSTICE WHITE, JOINED BY BURGER, BLACKMUN, REHNQUIST, STEVENS, AND O'CONNOR; WITH CONCURRING OPINION OF JUSTICE O'CONNOR, JOINED BY BURGER AND REHNQUIST; AND DISSENTING OPINION OF JUSTICE BRENNAN, JOINED BY MARSHALL, IN *BROCKETT V. SPOKANE ARCADES, INC.*, NO. 84-28, 472 U.S. 491, 86 L.ED.2D 394, 105 S.CT. 2794 (1985), REVERSING 9TH CIRCUIT COURT OF APPEALS, WHICH HAD HELD THE WASHINGTON STATE PUBLIC NUISANCE STATUTE TO BE UNCONSTITUTIONALLY BROAD.

(Reference: *Brief Amicus Curiae of James J. Clancy, etc.*, ...Page 28, lines 11, 37.)

[472 US 491]

DONALD C. BROCKETT, Appellant

v

SPOKANE ARCADES, INC., et al. (No. 84-28)

KENNETH EIKENBERRY, Attorney General of Washington, et al., Appellants

v

J-R DISTRIBUTORS, INC., et al. (84-143)

472 US 491, 86 L Ed 2d 394, 105 S Ct 2794

[Nos. 84-28 and 84-143]

Argued February 20, 1985. Decided June 19, 1985.

Decision: Invalidation in its entirety of state statute aimed at preventing and punishing the publication of obscene materials held improper.

SUMMARY

Various purveyors of sexually oriented books and movies filed suit for declaratory and injunctive relief challenging the constitutionality of a Washington moral nuisance statute, not yet enforced, which established penalties for persons dealing in "obscene matter," defined in part as matter appealing to a "prurient" interest, which in turn was defined as "that which incites lasciviousness or lust." The United States District Court for the Eastern District of Washington rejected all constitutional challenges to the validity of the statute (544 F Supp 1034). The United States Court of Appeals for the Ninth Circuit reversed, holding that the statute was unconstitutionally overbroad in violation of the First Amendment because, by including "lust" in its definition of "prurient," it reached material which merely stimulated normal sexual responses; and that it was appropriate to invalidate the entire statute on its face, even though it had not yet been authoritatively interpreted or enforced, because the very existence of the statute might have a chilling effect on protected expression (725 F2d 482).

On appeal, the United States Supreme Court reversed and remanded. In an opinion by WHITE, J., joined by BURGER, Ch. J., and BLACKMUN, REHN-

Briefs of Counsel, p. 789, infra.

QUIST, STEVENS, and O'CONNOR, JJ., it was held that the First Amendment involvement in this case did not render inapplicable the rule that a federal court should not extend its invalidation of a statute further than necessary to dispose of the case before it, and that the statute in question should have been invalidated only insofar as the word "lust" is to be understood as reaching protected materials.

O'CONNOR, J., joined by BURGER, Ch. J., and REHNQUIST, J., concurred, expressing the view that the federal courts should have abstained from deciding the case and allowed the state courts an opportunity to construe the statute in the first instance.

BRENNAN, J., joined by MARSHALL, J., dissented, expressing the view that the statute was unconstitutionally overbroad and thus invalid on its face for the reasons stated in his dissent in Paris Adult Theaters I v Slaton (1973) 413 US 49, 37 L Ed 2d 446, 93 S Ct 2628.

POWELL, J., did not participate.

HEADNOTES

Classified to U.S. Supreme Court Digest, Lawyers' Edition

Constitutional Law § 930; Statutes § 58 — obscenity law — partial or facial invalidation for overbreadth

1a-1d. A state moral nuisance statute which is allegedly overbroad in violation of the First Amendment, in that its definition of the proscribed obscene matter includes "that which incites . . . lust" and thus purportedly reaches constitutionally protected material which arouses only a normal, healthy interest in sex, and which has been challenged by persons who desire to publish this sort of material and claim that they face punishment if they do so, should be invalidated only insofar as the word "lust" is to be understood as reaching protected materials and not in

TOTAL CLIENT-SERVICE LIBRARY® REFERENCES

16 Am Jur 2d, Constitutional Law §§ 260 et seq., 507; 50 Am Jur 2d, Lewdness, Indecency, and Obscenity §§ 3 et seq.; 73 Am Jur 2d, Statutes § 346

7 Am Jur Pl & Pr Forms (Rev), Constitutional Law, Forms 21, 38, 71, 73

18 Am Jur Proof of Facts 465, Obscenity—Motion Pictures

10 Am Jur Trials 1, Obscenity Litigation

USCS Constitution, First Amendment

US L Ed Digest, Appeal § 1258.5; Constitutional Law § 930; Statutes §§ 37, 38, 38.5, 58

L Ed Index to Annos, Freedom of Speech, Press, Religion, and Assembly; Indecency; Statutes

ALR Quick Index, Freedom of Speech and Press; Indecency, Lewdness, and Obscenity

Federal Quick Index, Censorship; Freedom of Speech and Press; Lewdness, Indecency, and Obscenity

Auto-Cite®: Any case citation herein can be checked for form, parallel references, later history and annotation references through the Auto-Cite computer research system.

ANNOTATION REFERENCES

Supreme Court's views as to overbreadth of legislation in connection with First Amendment rights. 45 L Ed 2d 725.

Supreme Court's development, since Roth v United States, of standards and principles determining concept of obscenity in context of right of free speech and press. 41 L Ed 2d 1257.

Modern concept of obscenity. 5 ALR3d 1158.

Validity of procedure designed to protect the public against obscenity. 5 ALR3d 1214.

its entirety, where such a limiting construction is feasible and will not invalidate the intent of the enacting legislature. (Brennan and Marshall, JJ., dissented from this holding.)

Appeal § 1258.5 — review — following lower federal court's construction of state statute

2. The United States Supreme Court will normally defer to the construction of a state statute given it by the lower federal courts; but this rule is not ironclad, and the court surely has the authority to differ with the lower federal courts as to the meaning of a state statute.

Constitutional Law § 930; Statutes § 58 — obscenity law — partial invalidation — effect of First Amendment issues

3. The involvement of the First Amendment in an action by purveyors of sexually oriented material challenging the constitutionality of an allegedly overbroad state moral nuisance statute does not render inapplicable the rule that a federal court should not extend its invalidation of a statute further than necessary to dispose of the case before it.

Constitutional Law § 930; Statutes §§ 37, 58 — partial or facial invalidation — First Amendment issues — where affected persons are parties

4. An individual whose own speech or expressive conduct may validly be prohibited or sanctioned may challenge a statute on its face where it also threatens others not before the court who desire to engage in legally protected expression but may refrain from doing so rather than risk prosecution or undertake to have the law declared partially invalid; and if the overbreadth is substantial, the law may not be enforced against anyone, including the party before the court, until it is narrowed to reach only unprotected activity; however, where the parties challenging the statute are those who desire to engage in protected speech which the overbroad statute purports to punish, or who seek to publish both protected and unprotected material, there is no want of a proper party to challenge the statute, and the statute may be declared invalid to the extent that it reaches too far but otherwise left intact.

Statutes § 38.5 — partial invalidation — legislative intent as to retention of valid part

5. The partial invalidation of a statute is improper if it is contrary to legislative intent in the sense that the legislature has passed an unseverable act or would not have passed it had it known that the challenged provision was invalid.

Statutes § 38 — partial invalidity — Washington law

6. Under Washington law, a statute is not to be declared unconstitutional in its entirety unless the invalid portions are unseverable and it cannot reasonably be believed that the legislature would have passed one without the other, or unless the elimination of the invalid part would render the remainder of the act incapable of accomplishing the legislative purposes.

SYLLABUS BY REPORTER OF DECISIONS

A Washington statute declares to be a "moral nuisance" any place "where lewd films are publicly exhibited as a regular course of business" or "in which lewd publications constitute a principal part of the stock in trade." The statute provides that "lewd matter" is synonymous with "obscene matter" and defines these terms to mean, inter alia, any matter which the average person, applying contemporary community standards, would find, when considered as a whole, "appeals to the prurient interest." "Prurient" is defined to mean "that which incites lasciviousness or lust." Appellees—various individuals and corporations who purvey sexually oriented books and movies—challenged the statute on First Amendment grounds in Federal District Court, seeking injunctive and declaratory relief. The District Court rejected appellees' constitutional challenges. The Court of Appeals reversed, invalidating the statute in its entirety on its face on the ground that the definition of "prurient" as including "lust" was unconstitutionally overbroad in that it reached constitutionally protected material that merely stimulated normal sexual responses.

Held: The Court of Appeals erred in facially invalidating the statute in its entirety.

(a) These cases are governed by the normal rule that partial, rather than facial, invalidation is the required course. Unless there are countervailing considerations, the Washington statute should have been invalidated only insofar as the word "lust" is to be understood as reaching protected materials.

(b) Since prurience may be constitutionally defined for the purposes of identifying obscenity as that which appeals to a shameful or morbid interest in sex, Roth v United States, 354 US 476, 1 L Ed 2d 1498, 77 S Ct 1304, 14 Ohio Ops 331, if the Washington statute were invalidated only insofar as the word "lust" is taken to include normal interest in sex, the statute would pass constitutional muster and would validly reach a whole range of obscene publications. Moreover, if the Court of Appeals thought that "lust" refers *only* to normal sexual appetites, it could have excised the word from the statute, since the definition also refers to "lasciviousness."

(c) Even if the statute had not defined prurience at all, there would have been no satisfactory ground for striking it down in its entirety. The statute itself contains a severability clause, and it is evident that if the statute were invalidated insofar as it proscribes materials that appeal to normal sexual appetites, the remainder of the statute would retain its effectiveness as a regulation of obscenity. In these circumstances, the issue of severability is no obstacle to partial invalidation.

725 F2d 482, reversed and remanded.

White, J., delivered the opinion of the Court, in which Burger, C. J., and Blackmun, Rehnquist, Stevens, and O'Connor, JJ., joined. O'Connor, J., filed a concurring opinion, in which Burger, C. J., and Rehnquist, J., joined. Brennan, J., filed a dissenting opinion, in which Marshall, J., joined. Powell, J., took no part in the decision of the cases.

APPEARANCES OF COUNSEL

Christine O. Gregoire argued the cause for appellants in 84-28 and 84-143.

John H. Weston argued the cause for appellees in 84-28 and 84-143.

Briefs of Counsel, p 789, infra.

OPINION OF THE COURT

[472 US 493]

Justice White delivered the opinion of the Court.

[1a] The question in this case is whether the Court of Appeals for the Ninth Circuit erred in invalidating in its entirety a Washington statute aimed at preventing and punishing the publication of obscene materials.

I

On April 1, 1982, the Washington state moral nuisance law became effective. Wash Rev Code §§ 7.48A.010–7.48A.900 (1983).[1] It sets forth a comprehensive scheme establishing criminal and civil penalties for those who deal in obscenity or prostitution. The statute declares to be a "moral nuisance" any place "where lewd films are publicly exhibited as a regular course of business" and any place of business "in which lewd publications constitute a principal part of the stock in trade." §§ 7.48A.020(1), (3). Subsection (2) of the "Definitions" section of the statute provides that "lewd matter" is synonymous with "obscene matter," and defines these terms to mean any matter:

"(a) Which the average person, applying contemporary community standards, would find, when considered as a whole, appeals to the prurient interest; and

"(b) Which explicitly depicts or describes patently offensive representations or descriptions of:

"(i) Ultimate sexual acts, normal or perverted, actual or simulated; or

"(ii) Masturbation, fellatio, cunnilingus, bestiality, excretory functions, or lewd exhibition of the genitals or genital area; or

[472 US 494]

"(iii) Violent or destructive sexual acts, including but not limited to human or animal mutilation, dismemberment, rape or torture; and

"(c) Which, when considered as a whole, and in the context in which it is used, lacks serious literary, artistic, political, or scientific value." § 7.48A.010(2).

The word "prurient," as used in subsection (2)(a), is defined in subsection (8) to mean "that which incites lasciviousness or lust." § 7.48A.010(8).

On April 5, four days after the effective date of the statute, appellees—various individuals and corporations who purvey sexually oriented books and movies to the adult public[2]—challenged the constitutionality of the statute in Federal District Court, seeking injunctive and declaratory relief. One of their assertions was that the statute's definition of "prurient" to include "that which incites . . . lust" was unconstitutionally overbroad because it reached material that aroused only a normal, healthy interest in sex and that the statute was therefore to be declared invalid on its face.[3] Appellees alleged that the sexually oriented films and books they sold were protected by the First Amendment, and that the state authorities would enforce the new legislation against them unless restrained by the Court. App 33. On April 13, the District Court for the Eastern District of Washington issued a preliminary injunction against enforcement of the statute. Id., at 35.

After trial, the District Court rejected all of appellees' constitutional challenges to the validity of the statute. 544 F

[472 US 495]

Supp 1034 (1982).[4] A divided panel of the Court of Appeals for the Ninth Circuit reversed. 725 F2d 482 (1984). It first held that a facial challenge to the allegedly overbroad statute was appropriate despite the fact that the law had not yet been authoritatively interpreted or enforced. This was necessary when First Amendment rights were at stake lest the very existence of the statute have a chilling effect on protected expression. The Court of Appeals acknowledged that facial invalidation required "substantial overbreadth," Broadrick v Oklahoma, 413 US 601, 37 L Ed 2d 830, 93 S Ct 2908 (1973), but concluded that the requirement applies only when the challenged statute regulates conduct, as opposed to "pure speech." 725 F2d, at 487. Nor did the court find this to be an appropriate case for abstention. See Railroad Comm'n v Pullman Co. 312 US 496, 85 L Ed 971, 61 S Ct 643 (1941).

Reaching the merits, the Court of Appeals held that by including "lust" in its definition of "prurient," the Washington state legislature had intended the statute to reach material that merely stimulated normal sexual responses, material that it considered to be constitutionally protected. Because in its view the statute did not lend itself to a saving construction by a state court and any application of the statute would depend on a determination of obscenity by reference to the "unconstitutionally overbroad" definition, the Court of Appeals declared the statute as a whole to be null and void.[5]

[472 US 496]

The defendant state and county officials separately appealed to this Court. We noted probable jurisdiction in both cases, 469 US 813, 83 L Ed 2d 25, 105 S Ct 76 (1984).[6]

1. An earlier moral nuisance law, Wash Rev Code § 7.48.052 et seq. (1983), adopted as an initiative measure in 1977, was struck down as an impermissible prior restraint. See Spokane Arcades, Inc. v Brockett, 631 F2d 135 (CA9 1980), summarily aff'd, 454 US 1022, 70 L Ed 2d 468, 102 S Ct 557 (1981).

2. Seven separate suits were originally filed in the District Court for the Eastern District of Washington, where they were consolidated.

3. Appellees also challenged the Washington statute's paraphrasing of the second and third parts of the test set forth in Miller v California, 413 US 15, 37 L Ed 2d 419, 93 S Ct 2607 (1973). See infra, at 497, 86 L Ed 2d, at 402. The District Court rejected these attacks, and the Court of Appeals did not address them. Appellees have not renewed these claims in this Court.

4. The District Court stayed its judgment to allow appellees to seek a stay pending appeal from the Court of Appeals, which the Court of Appeals subsequently granted. 725 F2d 482, 485 (1984). Thus, the statute was not enforced pending appeal.

5. Having struck down the statute in toto on overbreadth grounds, the Court of Appeals nevertheless went on to conclude that the statute's civil fine provisions were constitutionally invalid, on the theory that "the legislature will undoubtedly try again." 725 F2d, at 493. This part of the opinion was obviously unnecessary to the Court of Appeals' holding, and in view of our disposition of this case, will require reconsideration on remand.

6. Because there are no significant differences between the two cases, we do not distinguish between them in our discussion.

II

The Court of Appeals was of the view that neither Roth v United States, 354 US 476, 1 L Ed 2d 1498, 77 S Ct 1304, 4 Ohio Ops 2d 331 (1957), nor later cases should be read to include within the definition of obscenity those materials that appeal to only normal sexual appetites. Roth held that the protection of the First Amendment did not extend to obscene speech, which was to be identified by inquiring "whether to the average person, applying contemporary community standards, the dominant theme of the material taken as a whole appeals to prurient interest." Id., at 489, 1 L Ed 2d 1498, 77 S Ct 1304, 4 Ohio Ops 2d 331 (footnote omitted). Earlier in its opinion, id., at 487, n 20, 1 L Ed 2d 1498, 77 S Ct 1304, 4 Ohio Ops 2d 331, the Court had defined "material which deals with sex in a manner appealing to prurient interest" as:

"I.e., material having a tendency to excite lustful thoughts. Webster's New International Dictionary (Unabridged, 2d ed, 1949) defines *prurient*, in pertinent part, as follows:

"'. . . Itching; longing; uneasy with desire or longing; of persons, having itching, morbid, or lascivious longings; of desire, curiosity, or propensity, lewd. . . .'

"*Pruriency* is defined, in pertinent part, as follows:

"'. . . Quality of being prurient; lascivious desire or thought. . . .'

"See also Mutual Film Corp. v Industrial Comm'n, 236 US 230, 242 [59 L Ed 2d 552, 35 S Ct 387], where this Court said as to motion pictures: '. . . They take their attraction from the general interest, eager and wholesome it may be, in their subjects, but a *prurient interest may be excited and appealed to. . . .*' *(Emphasis added.)*

[472 US 497]

"We perceive no significant difference between the meaning of obscenity developed in the case law and the definition of the ALI, Model Penal Code, § 207.10(2) (Tent Draft No. 6, 1957), viz.:

"'. . . A thing is obscene if, considered as a whole, its predominant appeal is to prurient interest, i. e., a shameful or morbid interest in nudity, sex, or excretion, and if it goes substantially beyond customary limits of candor in description or representation of such matters. . . .' See Comment, id., at 10, and the discussion at page 29 et seq."

Under Roth, obscenity was equated with prurience and was not entitled to First Amendment protection. Nine years later, however, the decision in Memoirs v Massachusetts, 383 US 413, 16 L Ed 2d 1, 86 S Ct 975 (1966), established a much more demanding three-part definition of obscenity, a definition that was in turn modified in Miller v California, 413 US 15, 37 L Ed 2d 419, 93 S Ct 2607 (1973).[7] The Miller guidelines for identifying obscenity are:

"(a) whether 'the average person, applying contemporary community standards' would find that the work, taken as a whole, appeals to the prurient interest, Kois v Wisconsin, [408 US,] at 230 [33 L Ed 2d 312, 92 S Ct 2245], quoting Roth v United States, supra, at 489 [1 L Ed 2d 1498, 77 S Ct 1304, 4 Ohio Ops 2d 331]; (b) whether the work depicts or describes, in a patently offensive way, sexual conduct specifically defined by the applicable state law; and (c) whether the work, taken as a whole, lacks serious literary, artistic, political, or scientific value." Id., at 24, 37 L Ed 2d 419, 93 S Ct 2607.

Miller thus retained, as had Memoirs, the Roth formulation as the first part of this test, without elaborating on or disagreeing

[472 US 498]

with the definition of "prurient interest" contained in the Roth opinion.

The Court of Appeals was aware that Roth had indicated in footnote 20 that material appealing to the prurient interest was "material having a tendency to excite lustful thoughts" but did not believe that Roth had intended to characterize as obscene material that provoked only normal, healthy sexual desires. We do not differ with that view. As already noted, material appealing to the "prurient interest" was itself the definition of obscenity announced in Roth; and we are quite sure that by using the words "lustful thoughts" in footnote 20, the Court was referring to sexual responses over and beyond those that would be characterized as normal. At the end of that footnote, as the Court of Appeals observed, the Roth opinion referred to the Model Penal Code definition of obscenity—material whose predominate appeal is to "a shameful or morbid interest in nudity, sex, or excretion" and indicated that it perceived no significant difference between that definition and the meaning of obscenity developed in the case law. This effectively negated any inference that "lustful thoughts" as used earlier in the footnote was limited to or included normal sexual responses.[8] It would require more

[472 US 499]

than the possible ambiguity in footnote 20 to lead us to believe that the Court intended to characterize as obscene and exclude from the protection of the First Amendment any and all speech that aroused any sexual responses, whether normal or morbid.

7. The basic difference between the Memoirs test and the Miller test was the Memoirs requirement that in order to be judged obscene, a work must be "utterly without redeeming social value." 383 US, at 418, 16 L Ed 2d 1, 86 S Ct 975. Miller settled on the formulation, "whether the work, taken as a whole, lacks serious literary, artistic, po'itical, or scientific value." 413 US, at 24, 37 L Ed 2d 419, 93 S Ct 2607.

8. This conclusion is bolstered by a subsequent footnote, 354 US, at 489, n 26, 1 L Ed 2d 1498, 77 S Ct 1304, 14 Ohio Ops 2d 331, referring to a number of cases defining obscenity in terms of "lust" or "lustful." See Parmelee v United States, 72 App DC 203, 210, 113 F2d 729, 736 (1940) (material is protected if "the erotic matter is not introduced to promote lust"); United States v Dennett, 39 F2d 564, 569 (CA2 1930) (sex education pamphlet not obscene because tendency is to "rationalize and dignify [sex] emotions rather than to arouse lust"); United States v One Book Called "Ulysses," 5 F Supp 182, 184 (SDNY 1933), aff'd, 72 F2d 705 (CA2 1934) (meaning of the word "obscene" is "(t)ending to stir the sex impulses or to lead to sexually impure and lustful thoughts"); Commonwealth v Isenstadt, 318 Mass 543, 549-550, 62 NE2d 840, 844 (1945) (material is obscene if it has "a substantial tendency to deprave or corrupt its readers by inciting lascivious thoughts or arousing lustful desire"); Missouri v Becker, 364 Mo 1079, 1085, 272 SW2d 283, 286 (1954) (materials are obscene if they "incite lascivious thoughts, arouse lustful desire"); Adams Theatre Co. v Keenan, 12 NJ 267, 272, 96 A2d 519, 521 (1953) (Brennan, J.) (question is whether "dominant note of the presentation is erotic allurement 'tending to excite lustful and lecherous desire' ").

Appellants urge that because Roth defined prurience in terms of lust, the Washington obscenity statute cannot be faulted for defining "prurient" as that which "incites lasciviousness or lust." Whatever Roth meant by "lustful thoughts"—and the State agrees that the Court did not intend to include materials that provoked only normal sexual reactions—that meaning should be attributed to the term "lust" appearing in the state law. On this basis, the State submits that the statute cannot be unconstitutional for defining prurience in this manner.

The Court of Appeals rejected this view, holding that the term "lust" had acquired a far broader meaning since Roth was decided in 1957. The word had come to be understood as referring to a "healthy, wholesome, human reaction common to millions of well-adjusted persons in our society," rather than to any shameful or morbid desire. 725 F2d, at 490. Construed in this way, the statutory definition of prurience would include within the first part of the Miller definition of obscenity material that is constitutionally protected by the First Amendment: material that, taken as a whole, does no more than arouse, "good, old fashioned, healthy" interest in sex. Id., at 492, 1 L Ed 2d 1498, 77 S Ct 1304, 4 Ohio Ops 2d 331. The statute, the Court of Appeals held, was thus overbroad and invalid on its face.

[2] Appellants fault the Court of Appeals for construing the statute in this manner. Normally, however we defer to the construction of a state statute given it by the lower federal courts. Chardon v Fumero Soto, 462 US 650, 654-655, n 5, 77 L Ed 2d 74, 103 S Ct 2611 (1983); Haring v Prosse, 462 US 306, 314, n 8, 76 L Ed 2d 595, 103 S Ct 2368 (1983); Pierson v Ray, 386 US 547, 558, n 12, 18 L Ed 2d 288, 87 S Ct 513 (1967); General Box

[472 US 500]

Co. v United States, 351 US 159, 165, 100 L Ed 1055, 76 S Ct 728 (1956). We do so not only to "render unnecessary review of their decisions in this respect," Cort v Ash, 422 US 66, 73, n 6, 45 L Ed 2d 26, 95 S Ct 2080 (1975), but also to reflect our belief that district courts and courts of appeals are better schooled in and more able to interpret the laws of their respective States. See Bishop v Wood, 426 US 341, 345-346, 48 L Ed 2d 684, 96 S Ct 2074 (1976); Gooding v Wilson, 405 US 518, 524, and n 2, 31 L Ed 2d 408, 92 S Ct 1103 (1972). The rule is not ironclad, however, and we surely have the authority to differ with the lower federal courts as to the meaning of a state statute.[9] It may also be that, other things being equal, this would not be a case for deferring to the

9. The Court has stated that it will defer to lower courts on state-law issues unless there is "plain" error, Palmer v Hoffman, 318 US 109, 118, 87 L Ed 645, 63 S Ct 447, 144 ALR 719 (1943); the view of the lower court is "clearly wrong," The Tungus v Skovgaard, 358 US 588, 596, 3 L Ed 2d 524, 79 S Ct 503, 71 ALR2d 1280 (1959); or the construction is "clearly erroneous," United States v Durham Lumber Co. 363 US 522, 527, 4 L Ed 2d 1371, 80 S Ct 1282 (1960), or "unreasonable," Propper v Clark, 337 US 472, 486-487, 93 L Ed 1480, 69 S Ct 1333 (1949). On occasion, then, the Court has refused to follow the views of a lower federal court on an issue of state law. In Cole v Richardson, 405 US 676, 683-684, 31 L Ed 2d 593, 92 S Ct 1332 (1972), e.g., we refused to accept a three-judge District Court's construction of a single statutory word based on the dictionary definition of that language where more reliable indicia of the legislative intent were available.

Court of Appeals.[10] But we pretermit this

[472 US 501]

issue, for the Court of Appeals fell into another error when it invalidated the statute on its face because of its "unconstitutionally overbroad" definition of obscenity.

III

Appellants insist that the error was in finding any invalidity in the statute, even accepting the court's construction of the word "lust." To be obscene under Miller, a publication must, taken as a whole, appeal to the prurient interest, must contain patently offensive depictions or descriptions of specified sexual conduct, and on the whole have no serious literary, artistic, political, or scientific value. Appellants submit that the latter two Miller guidelines, which the Washington statute faithfully follows, will completely cure any overbreadth that may inhere in the statute's definition of prurience as construed by the Court of Appeals. We are not at all confident that this would always be the case. It could be that a publication that on the whole arouses normal sexual responses would be declared obscene because it contains an isolated example of conduct required by the second guideline and because it also fails to have the redeeming value required by the third. Under the existing case law, material of that kind is not without constitutional protection."

[1b] Facial invalidation of the statute was nevertheless improvident. We call to mind two of the cardinal rules governing the federal courts: "'[o]ne, never to anticipate a question of constitutional law in advance of the necessity of deciding it; the other never to formulate a rule of constitutional law broader than is required by the precise facts to which it is to be applied.'" United States v Raines, 362 US 17, 21, 4 L Ed 2d 524, 80 S Ct 519

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(1960), quoting Liverpool, New York & Philadelphia S.S. Co. v Commissioners of Emigration, 113 US 33, 39, 28 L Ed 899, 5 S Ct 352 (1885). Citing a long line of cases, Raines also held that "[k]indred to these rules is the rule that one to whom application of a statute is constitutional will not be heard to attack the statute on the ground that impliedly it might also be taken as applying to other persons or other situations in which its application might be unconstitutional." These guideposts are at the

10. Appellants make a strong argument that the Court of Appeals erred in construing the Washington statute. The Court of Appeals relied on dictionary definitions of "prurient" and "lust," saying that the most recent edition of Webster's Third New International Dictionary (Unabridged, 4th ed. 1976) did not include the word "lust" in its definition of "prurient." But neither did the edition of Webster cited by the Roth court. Webster's Second Edition defined "lust" as (excluding the obsolete meanings):
"sensuous desire; bodily appetite; specif. and most commonly, sexual desire, as a violent or degrading passion." Webster's New International Dictionary (Unabridged, 2d ed, 1949).
Furthermore, and of some significance, the word "lust" is defined in Webster's Third New International (Unabridged, 5th ed, 1981) in pertinent part as follows:
"1 obs. a: PLEASURE, GRATIFICATION, DELIGHT . . . b: personal inclination: WISH, WHIM . . . c: VIGOR, FERTILITY . . . 2: sexual desire esp. of a violent self-indulgent character: LECHERY, LASCIVIOUSNESS . . . 3 a: an intense longing: CRAVING . . . b: EAGERNESS, ENTHUSIASM."

11. Roth specifically rejected a standard of obscenity that "allowed material to be judged merely by the effect of an isolated excerpt upon particularly susceptible persons." 354 US, at 488-489, 1 L Ed 2d 1498, 77 S Ct 1304, 4 Ohio Ops 2d 331 (discussing Queen v Hicklin, [1868] LR 3 Q B 360).

bottom of the "elementary principle that the same statute may be in part constitutional and in part unconstitutional, and that if the parts are wholly independent of each other, that which is constitutional may stand while that which is unconstitutional will be rejected." Allen v Louisiana, 103 US 80, 83-84, 26 L Ed 318 (1881), quoted with approval in Field v Clark, 143 US 649, 695-696, 36 L Ed 294, 12 S Ct 495 (1892). Absent "weighty countervailing" circumstances, Raines, supra, at 22, 4 L Ed 2d 524, 80 S Ct 519, this is the course that the Court has adhered to. Reagan v Farmers' Loan & Trust Co. 154 US 362, 395-396, 38 L Ed 1014, 14 S Ct 1047 (1894); Champlin Refining Co. v Corporation Comm'n, 286 US 210, 234-235, 76 L Ed 1062, 52 S Ct 559, 86 ALR 403 (1932); Watson v Buck, 313 US 387, 395-396, 85 L Ed 1416, 61 S Ct 962, 136 ALR 1426 (1941); Buckley v Valeo, 424 US 1, 108, 46 L Ed 2d 659, 96 S Ct 612 (1976). Just this Term, in Tennessee v Garner, 471 US 1, 85 L Ed 2d 1, 105 S Ct 1694 (1985), we held unconstitutional a state statute authorizing the use of deadly force against fleeing suspects, not on its face, but only insofar as it authorized the use of lethal force against unarmed and nondangerous suspects.

[3] Nor does the First Amendment involvement in this case render inapplicable the rule that a federal court should not extend its invalidation of a statute further than necessary to dispose of the case before it. Buckley v Valeo, supra, illustrates as much. So does Cantwell v Connecticut, 310 US 296, 84 L Ed 1213, 60 S Ct 900, 128 ALR 1352 (1940), where the Court did not invalidate the state offense of "breach of the peace" on its face but only to the extent that it was construed and applied to prevent the peaceful distribution of religious literature on the streets. In Marsh v Alabama, 326 US 501, 90 L Ed 265, 66 S Ct 276 (1946), the Court struck

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down a state trespass law only "[i]nsofar as the State has attempted to impose criminal punishment" on those distributing literature on the streets of a company town. Id., at 509, 90 L Ed 265, 66 S Ct 276. NAACP v Button, 371 US 415, 9 L Ed 2d 405, 83 S Ct 328 (1963), did not facially invalidate the State's rules against solicitation by attorneys but only as they were sought to be applied to the activities of the NAACP involved in that case. Id., at 419, 439, 9 L Ed 2d 405, 83 S Ct 328. More recently, in United States v Grace, 461 US 171, 75 L Ed 2d 736, 103 S Ct 1702 (1983), we declined to invalidate on its face a federal statute prohibiting demonstrations on the Supreme Court grounds and confined our holding to the invalidity of the statute as applied to picketing on the public sidewalks surrounding the building. Id., at 175, 75 L Ed 2d 736, 103 S Ct 1702.

[4] For its holding that in First Amendment cases an overbroad statute must be stricken down on its face, the Court of Appeals relied on that line of cases exemplified by Thornhill v Alabama, 310 US 88, 84 L Ed 1093, 60 S Ct 736 (1940), and more recently by Village of Schaumburg v Citizens for a Better Environment, 444 US 620, 63 L Ed 2d 73, 100 S Ct 826 (1980). In those cases, an individual whose own speech or expressive conduct may validly be prohibited or sanctioned is permitted to challenge a statute on its face because it also threatens others not

before the court—those who desire to engage in legally protected expression but who may refrain from doing so rather than risk prosecution or undertake to have the law declared partially invalid. If the overbreadth is "substantial,"[12] the law may not be enforced against anyone, including the party before the court, until it is narrowed to reach only unprotected activity, whether by

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legislative action or by judicial construction or partial invalidation. Broadrick v Oklahoma, 413 US 601, 37 L Ed 2d 830, 93 S Ct 2908 (1973).

It is otherwise where the parties challenging the statute are those who desire to engage in protected speech that the overbroad statute purports to punish, or who seek to publish both protected and unprotected material. There is then no want of a proper party to challenge the statute, no concern that an attack on the statute will be unduly delayed or protected speech discouraged. The statute may forthwith be declared invalid to the extent that it reaches too far, but otherwise left intact.

[1c] The cases before us are ones governed by the normal rule that partial, rather than facial, invalidation is the required course. The Washington statute was faulted by the Court of Appeals only because it reached material that incited normal as well as unhealthy interest in sex, and appellees, or some of them, desiring to publish this sort of material, claimed that they faced punishment if they did so. Unless there are countervailing considerations, the Washington law should have been invalidated only insofar as the word "lust" is to be understood as reaching protected materials.

The Court of Appeals was of the view that the term "lust" did not lend itself to a limiting construction and that it would not be feasible to separate its valid and invalid applications. Even accepting the Court of Appeals' construction of "lust," however, we are unconvinced that the identified overbreadth is incurable and would taint all possible applications of the statute, as was the case in Secretary of State of Maryland v Joseph H. Munson Co. 467 US 947, 81 L Ed 2d 786, 104 S Ct 2839 (1984). See also City Council of Los Angeles v Taxpayers for Vincent, 466 US 789, 796-799, and nn 12-16, 80 L Ed 2d 772, 104 S Ct 2118 (1984). If, as we have held, prurience may be constitutionally defined for the purposes of identifying obscenity as that which appeals to a shameful or morbid interest in sex, Roth v United States, 354 US 476, 1 L Ed 2d 1498, 77 S Ct 1304, 4 Ohio Ops 2d 331 (1957), it is equally certain that if the statute at issue here is invalidated only insofar as the word "lust" is taken to include

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normal interest in sex, the statute would pass constitutional muster and would validly reach the whole range of obscene publications. Furthermore, had the Court of Appeals thought that "lust"

12. The Court of Appeals erred in holding that the Broadrick v Oklahoma, 413 US 601, 37 L Ed 2d 830, 93 S Ct 2908 (1973), substantial overbreadth requirement is inapplicable where pure speech rather than conduct is at issue. New York v Ferber, 458 US 747, 772, 73 L Ed 2d 1113, 102 S Ct 3348 (1982), specifically held to the contrary. Because of our disposition of these cases, we do not address the issue whether the overbreadth of the Washington statute, in relation to its legitimate reach, is substantial and warrants a declaration of facial invalidity. See Secretary of State of Maryland v Joseph H. Munson Co. 467 US 947, 964-965, 81 L Ed 2d 786, 104 S Ct 2839 (1984); CSC v Letter Carriers, 413 US 548, 580-581, 37 L Ed 2d 796, 93 S Ct 2880 (1973).

refers *only* to normal sexual appetites, it could have excised the word from the statute entirely, since the statutory definition of prurience referred to "lasciviousness" as well as "lust." Even if the statute had not defined prurience at all, there would have been no satisfactory ground for striking the statute down in its entirety because of invalidity in all of its applications.[13]

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[1d, 5, 6] Partial invalidation would be improper if it were contrary to legislative intent in the sense that the legislature had passed an inseverable Act or would not have passed it had it known the challenged provision was invalid. But here the statute itself contains a severability clause;[14] and under Washington law, a statute is not to be declared unconstitutional in its entirety unless "the invalid provisions are unseverable and it cannot reasonably be believed that the legislature would have passed the one without the other, or unless the

13. According to appellees, the vast majority of state statutes either leave the word "prurient" undefined or adopt a definition using the words "shameful or morbid." Brief for Appellees 26-27. One State, New Hampshire, defines prurient interest as "an interest in lewdness or lascivious thoughts." NH Rev Stat Ann §§ 650:(1)(I)-(IV)(a) (Supp 1983). Mississippi is apparently the only State other than Washington to use the word "lust" in its definition of "prurient." Miss Code Ann § 97-29-103(1)(a) (Supp 1984) ("a lustful, erotic, shameful, or morbid interest in nudity, sex or excretion"). The District Court for the Northern District of Mississippi has issued a preliminary injunction against enforcement of the statute, partly on the ground that "[t]he inclusion of the terms lustful and erotic [in the definition of prurient] would permit the application of the statute to arguably protected materials." Goldstein v Allain, 568 F Supp 1377, 1385 (1983), appeal stayed pending trial on the merits, Case No. 83-4452 (CA5, June 20, 1984).

Some lower courts considering the issue have used the words "shameful or morbid" in describing the "prurient interest" that distinguishes obscene materials. See, e. g., Red Bluff Drive-In, Inc. v Vance, 648 F2d 1020, 1026 (CA5 1981), cert denied sub nom. Theatres West, Inc. v Holmes, 455 US 913, 71 L Ed 2d 453, 102 S Ct 1264 (1982); Leach v American Booksellers Assn., Inc. 582 SW2d 738, 749-750 (Tenn 1979). Others, however, have used "lust" in connection with definitions of "prurient," reading the word as connoting a sense of shame or debasement, or relying on its use in Roth. See, e. g., United States v 35 MM. Motion Picture Film Entitled "Language of Love," 432 F2d 705, 711-712 (CA2 1970); Childs v Oregon, 431 F2d 272, 275 (CA9 1970); Flying Eagle Publications, Inc. v United States, 273 F2d 799, 803 (CA1 1960).

An obscenity statute that leaves the word "prurient" undefined, or rather, defined only by case law has been sustained. See Red Bluff Drive-In, Inc. v Vance, supra, at 1026. See also Ward v Illinois, 431 US 767, 775, 52 L Ed 2d 738, 97 S Ct 2085 (1977) (state obscenity statute not overbroad for failure to expressly describe the kinds of sexual conduct intended to be referred to under part (b) of Miller guidelines, where state court had construed statute to incorporate the examples of sexual conduct mentioned in Miller). A predecessor of the Washington statute at issue here similarly used the word "prurient" without defining it. Wash Rev Code § 7.48.050 et seq. (1983). The Court of Appeals for the Ninth Circuit struck down the statute on other grounds, but apparently the use of the word "prurient" was not challenged. See Spokane Arcades v Brockett, 631 F2d, at 136, n 1. An earlier predecessor statute used only the word "obscene," without any further definition whatsoever. The Washington Supreme Court construed the statute to incorporate the Roth-Miller test, saving it from unconstitutional vagueness. See State v J-R Distributors, Inc. 82 Wash 2d 584, 602-603, 512 P2d 1049, 1061 (1973). The evident likelihood that the Washington courts would construe the instant statute to conform with the Miller standards also counsels against facial invalidation in this case. Cf. Time, Inc. v Hill, 385 US 374, 17 L Ed 2d 456, 87 S Ct 534 (1967).

14. "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." Wash Rev Code § 7.48A.900 (1983).

elimination of the invalid part would render the remainder of the act incapable of accomplishing the legislative purposes." State v Anderson, 81 Wash 2d 234, 236, 501 P2d 184, 185-186 (1972).[15] It would be frivolous to suggest, and

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no one does, that the Washington Legislature, if it could not proscribe materials that appealed to normal as well as abnormal sexual appetites, would have refrained from passing the moral nuisance statute. And it is quite evident that the remainder of the statute retains its effectiveness as a regulation of obscenity. In these circumstances, the issue of severability is no obstacle to partial invalidation, which is the course the Court of Appeals should have pursued.

The judgment of the Court of Appeals is accordingly reversed, and the case is remanded for further proceedings consistent with this opinion.

So ordered.

Justice Powell took no part in the decision of these cases.

SEPARATE OPINIONS

Justice O'Connor, with whom The Chief Justice and Justice Rehnquist join, concurring.

Only days after the State of Washington adopted the moral nuisance law at issue here, appellees launched a constitutional attack in Federal District Court. Although the statute has never been enforced or authoritatively interpreted by a state court, appellees allege that it applies to constitutionally protected expression and is facially invalid. Because I believe that the federal courts should have abstained and allowed the Washington courts an opportunity to construe the state law in the first instance, I think the proper disposition of these cases would be to vacate the judgment of the Court of Appeals on that ground. The Court, however, rejects that course and reaches the merits of the controversy. I join the opinion of the Court because I agree that the Court of Appeals erred in declaring the statute invalid on its face.

[472 US 508]

Although federal courts generally have a duty to adjudicate federal questions properly before them, this Court has long recognized that concerns for comity and federalism may require federal courts to abstain from deciding federal constitutional issues that are entwined with the interpretation of state law. In Railroad Comm'n v Pullman Co. 312 US 496, 85 L Ed 971, 61 S Ct 643 (1941), the Court held that where uncertain questions of state law must be resolved before a federal constitutional question can be decided, federal courts should abstain until a state court has addressed the state questions. Id., at 501, 85 L Ed 971, 61 S Ct 643; see also Hawaii Housing Authority v Midkiff, 467 US 229, 236-237, 81 L Ed 2d 186, 104 S Ct 2321 (1984). This doctrine of abstention acknowledges that federal courts should avoid the unnecessary resolu-

15. This standard is similar to that which we would apply in determining the severability of a federal statute: " 'Unless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law.' " See Buckley v Valeo, 424 US 1, 108-109, 46 L Ed 2d 659, 96 S Ct 612 (1976), quoting Champlin Refining Co. v Corporation Comm'n, 286 US 210, 234, 76 L Ed 1062, 52 S Ct 559, 86 ALR 403 (1932).

tion of federal constitutional issues and that state courts provide the authoritative adjudication of questions of state law.

Attention to the policies underlying abstention makes clear that in the circumstances of these cases, a federal court should await a definitive construction by a state court rather than precipitously indulging a facial challenge to the constitutional validity of a state statute. There can be no doubt that a state obscenity statute concerns important state interests. Such statutes implicate "the quality of life and the total community environment, the tone of commerce in the great city centers, and, possibly, the public safety itself." Paris Adult Theatre I v Slaton, 413 US 49, 58, 37 L Ed 2d 446, 93 S Ct 2628 (1973). The nature of the overbreadth claim advanced by appellees suggests that abstention was required because the Washington statute is "fairly subject to an interpretation which will render unnecessary or substantially modify the federal constitutional question." Harman v Forssenius, 380 US 528, 535, 14 L Ed 2d 50, 85 S Ct 1177 (1965).

The First Amendment overbreadth doctrine allows a challenge to the validity of a statute on its face only if the law is substantially overbroad. City Council of Los Angeles v Taxpayers for Vincent, 466 US 789, 799-801, 80 L Ed 2d 772, 104 S Ct 2118 (1984); New York v Ferber, 458 US 747, 769-773, 73 L Ed 2d 1113, 102 S Ct 3348 (1982). Thus, analysis of the constitutional claims advanced by appellees necessarily

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requires construction of the Washington statute to assess its scope. Id., at 769, n 24, 73 L Ed 2d 1113, 102 S Ct 3348; Broadrick v Oklahoma, 413 US 601, 618, n 16, 37 L Ed 2d 830, 93 S Ct 2908 (1973) ("[A] federal court must determine what a state statute means before it can judge its facial constitutionality"). Furthermore, a narrowing construction of a statute might obviate any challenge on overbreadth grounds. E. g., id., at 617-618, 37 L Ed 2d 830, 93 S Ct 2908 (relying on interpretation of State Personnel Board and Attorney General to reject overbreadth claim). Where a state statute has never been construed or applied, it seems rather obvious that interpretation of the statute by a state court could substantially alter the resolution of any claim that the statute is facially invalid under the Federal Constitution.

The Court of Appeals opined that the Washington statute is not susceptible to a limiting construction and therefore any interpretation by the state court would "neither eliminate nor materially change the constitutional issues presented here." 725 F2d 482, 488 (1984). This assertion is simply implausible. As noted in the opinion of this Court, the conclusion below that the state statute reaches *any* expression protected by the First Amendment rests on a dubious interpretation of the word "lust" as used in the statute. Ante, at 500-501, n 10, 86 L Ed 2d, at 404. Both the text and the background of the Washington statute indicate that the state legislature sought to conform the moral nuisance law to the constitutional standards outlined by this Court in Miller v California, 413 US 15, 37 L Ed 2d 419, 93 S Ct 2607 (1973). Moreover, the state courts have demonstrated their willingness to construe state obscenity laws in accord with Miller. See State v J-R Distributors, Inc. 82 Wash 2d 584, 512 P2d 1049 (1973), cert denied, 418 US 949, 41 L Ed 2d 1166, 94 S Ct 3217 (1974).

Apart from its unwarranted belief

that the statute is not fairly subject to a limiting construction, the Court of Appeals asserted that Pullman abstention should "almost never" apply where a state statute is challenged on First Amendment grounds "because the constitutional guarantee of free expression is, quite properly, always an area of particular

[472 US 510]

federal concern." 725 F2d, at 488. This Court has never endorsed such a proposition. See Babbitt v Farm Workers, 442 US 289, 306-312, 60 L Ed 2d 895, 99 S Ct 2301 (1979). On the contrary, even in cases involving First Amendment challenges to a state statute, absention may be required " 'in order to avoid unnecessary friction in federal-state relations, interference with important state functions, tentative decisions on questions of state law, and premature constitutional adjudication.' " Id., at 306, 60 L Ed 2d 895, 99 S Ct 2301, quoting Harman v Forssenius, supra, at 534, 14 L Ed 2d 50, 85 S Ct 1177; see also Harrison v NAACP, 360 US 167, 176-178, 3 L Ed 2d 1152, 79 S Ct 1025 (1959).

The decision of the Court of Appeals represents a premature and avoidable interference with the enforcement of state law in an area of special concern to the States. Speculation by a federal court about the meaning of a state statute in the absence of prior state court adjudication is particularly gratuitous when, as is the case here, the state courts stand willing to address questions of state law on certification from a federal court. Wash Rev Code §§ 2.60.010-2.60.900 (1983); Wash Rule App Proc 16.16. Cf. Bellotti v Baird, 428 US 132, 150-151, 49 L Ed 2d 844, 96 S Ct 2857 (1976). In my view, the state courts should have been afforded an opportunity to construe the Washington moral nuisance law in the first instance.

Justice Brennan, with whom Justice Marshall joins, dissenting.

We granted certiorari to consider the holding of the United States Court of Appeals for the Ninth Circuit that the Washington state obscenity law, Wash Rev Code §§ 7.48A.010-7.48A.900 (1983), is substantially overbroad and therefore invalid on its face under the First Amendment because it defines "prurient" in such a way as to reach constitutionally protected material that stimulates no more than a healthy interest in sex. This statute is, in my view, unconstitutionally overbroad and therefore invalid on its face for the reasons given in my dissent in Paris Adult Theatre I v Slaton, 413 US 49, 73, 37 L Ed 2d 446, 93 S Ct 2628 (1973). I would therefore affirm the judgment of the Court of Appeals.

APPENDIX G

TWO OPINIONS IN *WORLD FAMOUS DRINKING EMPORIUM, INC. V. CITY OF TEMPE, ARIZONA*, 820 F.2D 1079 (9TH CIR. 1987), HOLDING THAT, IN CASES WHERE THE *YOUNGER - HUFFMAN* ABSTENTION DOCTRINES APPLY, THE FEDERAL COMPLAINT MUST BE DISMISSED.

(Reference: *Brief Amicus Curiae of James J. Clancy, etc.*, ...Page 29, line 12.)

WORLD FAMOUS DRINKING EMPORIUM, INC., an Arizona corporation; Robert Eve and Michael Miller, Plaintiffs-Appellants,

v.

CITY OF TEMPE, a municipal corporation; Tempe Board of Adjustment; the Honorable Paul LaPrade, Maricopa County Superior Court Judge, Defendants-Appellees.

No. 85-2796.

United States Court of Appeals, Ninth Circuit.

Argued and Submitted Dec. 9, 1986.

Decided June 26, 1987.

Nightclub brought § 1983 suit challenging city's denial of an entertainment permit. The United States District Court for the District of Arizona, Paul G. Rosenblatt, J., granted city's motion to dismiss, and nightclub appealed. The Court of Ap-

peals, Tang, Circuit Judge, held that abstention was appropriate, considering that plaintiff failed to appeal adverse state judgments, thus satisfying requirement of ongoing state judicial proceedings, that important state interest was implicated in the proceedings, and that plaintiff had an adequate opportunity to raise its constitutional claim in state proceedings.

Affirmed.

Kennedy, Circuit Judge, concurred in the judgment with statement.

1. Federal Courts ⇐776

District court's determination that legal requirements of abstention are met is reviewed de novo.

2. Federal Courts ⇐65

If legal requirements for abstention are not met, there is no discretion to abstain.

3. Federal Courts ⇐813

If legal requirements for abstention are met, decision whether to abstain is reviewed for an abuse of discretion.

4. Federal Courts ⇐41

Abstention from exercising of federal jurisdiction is the exception, not the rule; absent significant countervailing interests, federal courts are obliged to exercise their jurisdiction.

5. Federal Courts ⇐41

Failure to exhaust state appellate remedies satisfies requirement that there be "ongoing judicial proceedings" in order to justify federal abstention.

6. Federal Courts ⇐53

A First Amendment challenge does not alter propriety of abstention in a case in which there are ongoing state judicial proceedings. U.S.C.A. Const.Amend. 1.

7. Federal Courts ⇐65

In evaluating whether ongoing state proceedings implicate important state interests, so as to justify abstention, Court of Appeals examines nature of the proceedings; fact that noncriminal proceedings closely relate to criminal proceedings, or vindicate important state policies, or are necessary for functioning of state judicial system, demonstrates an important state interest justifying abstention.

8. Federal Courts ⇐48

Abstention was proper with respect to § 1983 suit challenging city's denial of entertainment permit for nightclub featuring live entertainment in the form of female "go-go" and "flash" dancers; plaintiff's failure to appeal adverse judgments in two related state cases satisfied requirement of ongoing state judicial proceedings; important state interest was implicated in state proceedings and plaintiff had an adequate opportunity to litigate his constitutional claim in state forum. 42 U.S.C.A. § 1983.

Michael B. Scott, Phoenix, Ariz., for plaintiffs-appellants.

W. Kent Foree, Tempe, Ariz., for defendants-appellees.

Appeal from the United States District Court for the District of Arizona.

Before KENNEDY, TANG and THOMPSON, Circuit Judges.

TANG, Circuit Judge:

Appellant World Famous Drinking Emporium, Inc. ["World Famous"] appeals from the judgment of dismissal of its claim under 42 U.S.C. § 1983, entered upon the basis of the abstention doctrine as enunciated in *Younger v. Harris*, 401 U.S. 37, 91 S.Ct. 746, 27 L.Ed.2d 669 (1971). We have jurisdiction under 28 U.S.C. § 1291. We affirm.

FACTS AND PROCEEDINGS:

Pursuant to a municipal zoning ordinance[1] World Famous sought an entertainment use permit from Tempe for a nightclub featuring live entertainment in the form of female "go-go" and "flash" dancers.[2]

1. The ordinance read in pertinent part:
"4. The granting of such use permits rests with the sole discretion of the Board or Commission and Council upon finding that the use covered by the permit, the manner of conducting the same, and any building which is involved will not be detrimental to persons residing or working in the vicinity, to adjacent property, to the neighborhood, or to the public welfare in general....
In arriving at the above determination, the facts which shall be considered shall include, but not be limited to, the following:
a. Damage or nuisance arising from noise, smoke, odor, dust, vibration or illumination.
b. Hazard to persons and property from possible explosion, contamination, fire or flood.
c. Hazard occasioned by unusual volume or character of traffic.
d. Character of proposed building and site.
e. A demonstrated need of such use.
* * * * * *
6. Any use permits granted may be subject to such conditions as the Board, or Commission and Council deem applicable in order to fully carry out the provisions and intent of this Ordinance."

World Famous I

The Tempe Board of Adjustment ["the Board"] held its first hearing on World Famous' application in November 1983. The Board denied the application. Upon reconsideration in January 1984, the Board denied the application a second time. World Famous then sought to overrule the Board by way of a "special action" proceeding in Maricopa County Superior Court.[3] Judge Marquardt upheld the Board.

World Famous II

World Famous' continued operation led Tempe to file criminal proceedings and a civil enforcement action. In the latter action, Tempe sought preliminary and permanent injunctive relief. World Famous opposed Tempe's request by arguing, inter alia, the unconstitutionality of the zoning ordinance. Judge LaPrade granted the preliminary injunction on September 27, 1984. World Famous complied with the terms of the injunction and ceased presenting go-go and flash dancing. Following denial by the Arizona Supreme Court of special action relief, Tempe dismissed the criminal proceeding. Judge LaPrade denied World Famous' motions to dissolve the injunction and to dismiss the case, and granted Tempe's motion for summary judgment.

World Famous III

World Famous again sought the requisite use permit without success, and filed another special action petition in Superior Court, which was dismissed by Judge Howe on August 16, 1985.

World Famous IV

World Famous filed its § 1983 action on July 17, 1985 in United States District Court for the District of Arizona. Based solely upon the abstention doctrine as enunciated in *Younger v. Harris*, 401 U.S. 37, 91 S.Ct. 746, 27 L.Ed.2d 669 (1971), Judge Strand granted Tempe's motion to dismiss on September 8, 1985, stating in his memorandum:

> The issue of the constitutionality of the Tempe zoning ordinance is presently before the trial court in this case and would be subject to appellate review in the state court should an aggrieved party elect to take such action.

World Famous timely appealed.

DISCUSSION:

[1-3] The district court's determination that the legal requirements of abstention are met is reviewed de novo. *See Goldie's Bookstore, Inc. v. Superior Court of California*, 739 F.2d 466 (9th Cir.1984). Unless the legal requirements for abstention are met, there is no discretion to abstain. *C-Y Development Co. v. City of Redlands*, 703 F.2d 375, 377 (9th Cir.1983). If the legal requirements for abstention are met, the

2. The terms "go-go" and "flash" dancing in the instant case denote dancing by performers wearing opaque material covering the nipples and areolas of the breasts and bikini-type bottoms.

3. The scope of special action review is established by Rule 3 of the Arizona Rules of Procedure for Special Action, which reads in pertinent part:
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(a) Whether the defendant has failed to exercise discretion which he has a duty to exercise; or to perform a duty required by law as to which he has no discretion; or
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decision whether to abstain is reviewed for an abuse of discretion. *McIntyre v. McIntyre*, 771 F.2d 1316 (9th Cir.1985).

[4] Abstention from the exercise of federal jurisdiction is the exception, not the rule. *Colorado River Water Conservation District v. United States*, 424 U.S. 800, 96 S.Ct. 1236, 47 L.Ed.2d 483 (1976). Absent significant countervailing interests, the federal courts are obliged to exercise their jurisdiction. *Id.; County of Allegheny v. Frank Mashuda Co.*, 360 U.S. 185, 189, 79 S.Ct. 1060, 1063, 3 L.Ed.2d 1163 (1959). In *Younger v. Harris*, the Supreme Court held that federal courts should not enjoin pending state criminal proceedings except under extraordinary circumstances where the danger of irreparable loss is both great and immediate. 401 U.S. at 46, 91 S.Ct. at 751. *Id.* Three requirements have evolved for proper invocation of *Younger*: (1) ongoing state judicial proceedings; (2) implication of an important state interest in the proceedings; and (3) an adequate opportunity to raise federal questions in the proceedings. *Goldie's*, 739 F.2d at 469 (citing *Middlesex Ethics Committee v. Garden State Bar Association*, 457 U.S. 423, 432, 102 S.Ct. 2515, 2521, 73 L.Ed.2d 116 (1981)). Bad faith prosecution or harassment make abstention inappropriate even where these requirements are met. *Younger*, 401 U.S. at 47–49, 91 S.Ct. at 752–53. Similarly, satisfaction of the three requirements will not support abstention where a statute is flagrantly and patently violative of constitutional prohibitions. *Id.* at 53–54, 91 S.Ct. at 755–56.

1. Ongoing State Proceedings

[5, 6] At the time the district court abstained, World Famous had yet to appeal the adverse judgments in *World Famous II* and *World Famous III* to the state Supreme Court. Failure to exhaust state appellate remedies satisfies the requirement that there be "ongoing judicial proceedings" in order to justify federal abstention. *See Huffman v. Pursue, Ltd.*, 420 U.S. 592, 608–09, 95 S.Ct. 1200, 1210, 43 L.Ed.2d 482 (1975). A First Amendment challenge does not alter the propriety of abstention in such a case. *See Ohio Civil Rights Commission v. Dayton Christian Schools, Inc.*, — U.S. —, 106 S.Ct. 2718, 2724, 91 L.Ed.2d 512 (1986) (abstention proper where a First Amendment challenge may be raised in state court review of an administrative proceeding); *Huffman*, 420 U.S. at 612–13, 95 S.Ct. at 1212, 43 L.Ed.2d 482 (1975).

2. Important State Interest Implicated in State Proceedings

[7] *Younger* abstention is not limited to ongoing state criminal proceedings, *see, e.g., Huffman*, 420 U.S. at 608, 95 S.Ct. at 1210. It extends to certain civil proceedings provided those proceedings implicate important state interests. *See Ohio Civil Rights Commission v. Dayton Christian Schools, Inc.*, — U.S. —, 106 S.Ct. 2718, 2724, 91 L.Ed.2d 512 (1986) (state civil rights enforcement proceedings); *Moore v. Sims*, 442 U.S. 415, 99 S.Ct. 2371, 60 L.Ed.2d 994 (1979) (temporary removal of child in child-abuse context); *Trainor v. Hernandez*, 431 U.S. 434, 97 S.Ct. 1911, 52 L.Ed.2d 486 (1977) (proceeding for recovery of fraudulently obtained welfare benefits); *Middlesex*, 423 U.S. at 432, 102 S.Ct. at 2521 (state bar discipline proceedings); *Huffman*, 420 U.S. at 605, 95 S.Ct. at 1208 (state nuisance proceeding akin to criminal prosecution). In evaluating whether the proceedings implicate important state interests, we examine the nature of the proceedings. The fact that the noncriminal proceedings closely relate to criminal proceedings, *see Huffman*, 420 U.S. at 604, 95 S.Ct. at 1208, or vindicate important state policies, *see Trainor*, 431 U.S. at 445, 97 S.Ct. at 1919, or are necessary for the functioning of the state judicial system, *see Juidice v. Vail*, 430 U.S. 327, 336, 97 S.Ct. 1211, 1217, 51 L.Ed.2d 376 (1977), demonstrates an important state interest. *See Middlesex*, 457 U.S. at 431, 102 S.Ct. at 2520. In each of these cases, the state was a party to the proceedings. *See Miofsky v. Superior Court*, 703 F.2d 332, 337 (9th Cir.1983). *See also Worldwide Church of God, Inc. v. California*, 623 F.2d 613, 616 (9th Cir.1980) (state receivership order pursuant to investigation and regulation of fraud in charitable trusts), *cert. denied*, 449 U.S. 900, 101 S.Ct. 270, 66 L.Ed.2d 130 (1980); *Rosenthal v. Carr*, 614 F.2d 1219, 1220 (9th Cir.) (state bar disciplinary proceedings), *cert. denied* 447 U.S. 927, 100 S.Ct. 3024, 65 L.Ed.2d 1121 (1980).

[8] Here, Tempe brought a civil action in order to obtain compliance with an ordinance which aims at avoidance of public nuisances. It had the option of proceeding either by civil or criminal enforcement of its municipal ordinance; the option of criminal enforcement demonstrates the importance of the underlying state interest. *See Trainor*, 431 U.S. at 449–50, 97 S.Ct. at 1920–21 (Blackmun, J., concurring). Such an action, in aid of and closely related to Tempe's zoning ordinance and akin to a criminal prosecution, clearly involves an important state interest. *See Middlesex*, 457 U.S. at 434, 102 S.Ct. at 2522 (state bar disciplinary action); *Trainor*, 431 U.S. at 444, 97 S.Ct. at 1918 (civil proceeding brought to recover fraudulently obtained welfare payments); *Huffman*, 420 U.S. at 604, 95 S.Ct. at 1208 (public nuisance action). *Cf. Playtime Theatres, Inc. v. City of Renton*, 748 F.2d 527, 532–33 (9th Cir. 1984) (city's suit for declaratory relief not similar to criminal or "quasi-criminal" proceedings, nor did it involve interests vital to operation of state government), *rev'd on other grounds*, 475 U.S. 41, 106 S.Ct. 925, 89 L.Ed.2d 29 (1986); *Goldie's*, 739 F.2d at 469 (private unlawful detainer action does not implicate state interests); *Miofsky v. Superior Court*, 703 F.2d 332, 338 (9th Cir.1983) (private tort litigation does not implicate state interests). As such, the second requirement for the proper invocation of *Younger* abstention is satisfied.

3. Adequate Opportunity to Raise Federal Question

World Famous has failed to demonstrate how review of the adverse judgments in the state courts would not have permitted an opportunity to litigate its constitutional claims. That World Famous failed to avail itself of the opportunity to litigate its constitutional claim in the state forum, does not demonstrate that the state forum did not provide an opportunity to litigate that claim. *See Juidice v. Vail*, 430 U.S. 327, 337, 97 S.Ct. 1211, 1218, 51 L.Ed.2d 376 (1977). World Famous had an opportunity to pursue its constitutional claim upon appeal in the state courts,[4] and failed to do so. No more is required for *Younger* abstention. *See Ohio Civil Rights Commission*, 106 S.Ct. at 2724; *Moore*, 442 U.S. at 426, 99 S.Ct. at 2379; *Juidice*, 430 U.S. at 337, 97 S.Ct. at 1218.

Further, the record reveals no harassment or bad faith on the part of Tempe in bringing the civil enforcement and criminal proceedings which would make abstention improper. *See Huffman*, 420 U.S. at 611, 95 S.Ct., at 1211.

We hold abstention was proper and the merits of the constitutionality issue are not properly before this Court. *See Singleton v. Wulff*, 428 U.S. 106, 121, 96 S.Ct. 2868, 2877, 49 L.Ed.2d 826 (1976). *See also Huffman*, 420 U.S. at 602, 95 S.Ct. at 1207 (facial invalidity of statute is not exceptional circumstance justifying federal interference with state criminal proceedings) (citing *Younger*, 401 U.S. at 53–54, 91 S.Ct. at 754–55).

We also decline to consider World Famous' estoppel argument. World Famous fails to provide us with a reason for its failure to raise the estoppel issue below. Nor is the estoppel determination one of law whose proper resolution is beyond any doubt, *see Telco Leasing, Inc. v. Transwestern Title Co.*, 630 F.2d 691, 693 (9th Cir.1980). Accordingly, the estoppel issue is not properly before us. *See Kline v. Johns-Manville*, 745 F.2d 1217, 1221 (9th Cir.1984); *Taylor v. Sentry Life Insurance Co.*, 729 F.2d 652, 665–56 (9th Cir.1984).

4. We note that the scope of review of a special action provides for consideration of "[w]hether the defendant has proceeded ... without or in excess of jurisdiction or legal authority." Ariz. Rev.Stat.Ann., Rules of Procedure for Special Actions 3 (1973). It appears that the state courts could construe municipal ordinances in light of federal constitutional law. *Cf. Ohio Civil Rights Committee*, 106 S.Ct. at 2724.

Affirmance makes unnecessary the consideration of Tempe's assertion that World Famous' action is precluded by the adverse determinations below.

AFFIRMED.

KENNEDY, Circuit Judge, concurring:

General principles of abstention are distinct from the doctrine of dismissal for lack of jurisdiction pursuant to *Younger v. Harris*, 401 U.S. 37, 91 S.Ct. 746, 27 L.Ed.2d 669 (1971), and *Huffman v. Pursue, Ltd.*, 420 U.S. 592, 95 S.Ct. 1200 (1975). Only the latter rule is applicable here, and *Huffman* squarely controls. I concur in the judgment.

WORLD FAMOUS DRINKING EMPORIUM, INC., an Arizona corporation; Robert Eve and Michael Miller, Plaintiffs-Appellants,

v.

CITY OF TEMPE, a municipal corporation; Tempe Board of Adjustment; the Honorable Paul LaPrade, Maricopa County Superior Court Judge, Defendants-Appellees.

No. 85-2796.

United States Court of Appeals, Ninth Circuit.

Argued and Submitted Dec. 9, 1986.

Decided June 26, 1987.

As Amended Aug. 12, 1987.

Nightclub brought § 1983 suit challenging city's denial of an entertainment permit. The United States District Court for the District of Arizona, Paul G. Rosenblatt, J., granted city's motion to dismiss, and nightclub appealed. The Court of Ap-

peals, Tang, Circuit Judge, held that abstention was appropriate, considering that plaintiff failed to appeal adverse state judgments, thus satisfying requirement of ongoing state judicial proceedings, that important state interest was implicated in the proceedings, and that plaintiff had an adequate opportunity to raise its constitutional claim in state proceedings.

Affirmed.

Kennedy, Circuit Judge, concurred in the judgment with statement.

1. Federal Courts ⇐776

Decision whether to abstain under *Younger* is reviewable de novo.

2. Federal Courts ⇐813

When a case involves abstention on some ground other than *Younger*, e.g., abstention under *Railroad Commission v. Pullman Co.*, standard of review is one of abuse of discretion, with discretion to be exercised within the narrow and specific limits prescribed by the particular abstention doctrine involved.

3. Federal Courts ⇐41

Abstention from exercising of federal jurisdiction is the exception, not the rule; absent significant countervailing interests, federal courts are obliged to exercise their jurisdiction.

4. Federal Courts ⇐41

Failure to exhaust state appellate remedies satisfies requirement that there be "ongoing judicial proceedings" in order to justify federal abstention.

5. Federal Courts ⇐53

A First Amendment challenge does not alter propriety of abstention in a case in which there are ongoing state judicial proceedings. U.S.C.A. Const.Amend. 1.

6. Federal Courts ⇐65

In evaluating whether ongoing state proceedings implicate important state interests, so as to justify abstention, Court of Appeals examines nature of the proceedings; fact that noncriminal proceedings closely relate to criminal proceedings, or vindicate important state policies, or are necessary for functioning of state judicial system, demonstrates an important state interest justifying abstention.

7. Federal Courts ⇐48

Abstention was proper with respect to § 1983 suit challenging city's denial of entertainment permit for nightclub featuring live entertainment in the form of female "go-go" and "flash" dancers; plaintiff's failure to appeal adverse judgments in two related state cases satisfied requirement of ongoing state judicial proceedings; important state interest was implicated in state proceedings and plaintiff had an adequate opportunity to litigate his constitutional claim in state forum. 42 U.S.C.A. § 1983.

Michael B. Scott, Phoenix, Ariz., for plaintiffs-appellants.

W. Kent Faree, Tempe, Ariz., for defendants-appellees.

Appeal from the United States District Court for the District of Arizona.

Before KENNEDY, TANG and THOMPSON, Circuit Judges.

TANG, Circuit Judge:

Appellant World Famous Drinking Emporium, Inc. ["World Famous"] appeals from the judgment of dismissal of its claim under 42 U.S.C. § 1983, entered upon the basis of the abstention doctrine as enunciated in *Younger v. Harris*, 401 U.S. 37, 91 S.Ct. 746, 27 L.Ed.2d 669 (1971). We have jurisdiction under 28 U.S.C. § 1291. We affirm.

FACTS AND PROCEEDINGS:

Pursuant to a municipal zoning ordinance[1] World Famous sought an entertain-

1. The ordinance read in pertinent part:
"4. The granting of such use permits rests with the sole discretion of the Board or Commission and Council upon finding that the use covered by the permit, the manner of conducting the same, and any building which is involved will not be detrimental to persons residing or working in the vicinity, to adjacent property, to the neighborhood, or to the public welfare in general....
In arriving at the above determination, the facts which shall be considered shall include, but not be limited to, the following:
a. Damage or nuisance arising from noise, smoke, odor, dust, vibration or illumination.
b. Hazard to persons and property from possible explosion, contamination, fire or flood.
c. Hazard occasioned by unusual volume or character of traffic.
d. Character of proposed building and site.
e. A demonstrated need of such use.
* * * * * *
6. Any use permits granted may be subject to such conditions as the Board, or Commission and Council deem applicable in order to fully carry out the provisions and intent of this Ordinance."

ment use permit from Tempe for a nightclub featuring live entertainment in the form of female "go-go" and "flash" dancers.[2]

World Famous I

The Tempe Board of Adjustment ["the Board"] held its first hearing on World Famous' application in November 1983. The Board denied the application. Upon reconsideration in January 1984, the Board denied the application a second time. World Famous then sought to overrule the Board by way of a "special action" proceeding in Maricopa County Superior Court.[3] Judge Marquardt upheld the Board.

World Famous II

World Famous' continued operation led Tempe to file criminal proceedings and a civil enforcement action. In the latter action, Tempe sought preliminary and permanent injunctive relief. World Famous opposed Tempe's request by arguing, inter alia, the unconstitutionality of the zoning ordinance. Judge LaPrade granted the preliminary injunction on September 27, 1984. World Famous complied with the terms of the injunction and ceased presenting go-go and flash dancing. Following denial by the Arizona Supreme Court of special action relief, Tempe dismissed the criminal proceeding. Judge LaPrade denied World Famous' motions to dissolve the injunction and to dismiss the case, and granted Tempe's motion for summary judgment.

World Famous III

World Famous again sought the requisite use permit without success, and filed another special action petition in Superior Court, which was dismissed by Judge Howe on August 16, 1985.

World Famous IV

World Famous filed its § 1983 action on July 17, 1985 in United States District Court for the District of Arizona. Based solely upon the abstention doctrine as enunciated in *Younger v. Harris*, 401 U.S. 37, 91 S.Ct. 746, 27 L.Ed.2d 669 (1971), Judge Strand granted Tempe's motion to dismiss on September 8, 1985, stating in his memorandum:

> The issue of the constitutionality of the Tempe zoning ordinance is presently before the trial court in this case and would be subject to appellate review in the state court should an aggrieved party elect to take such action.

World Famous timely appealed.

DISCUSSION:

[1, 2] The decision whether to abstain under *Younger* is reviewable de novo. *Goldie's Bookstore, Inc. v. Superior Court of California*, 739 F.2d 466, 468 (9th Cir.1984). *See also Fresh International Corp. v. Agricultural Labor Relations Board*, 805 F.2d 1353, 1356 (9th Cir.1986). "When a case falls within the proscription of *Younger*, a district court must dismiss the federal action." *Id.* When a case involves absten-

2. The terms "go-go" and "flash" dancing in the instant case denote dancing by performers wearing opaque material covering the nipples and areolas of the breasts and bikini-type bottoms.

3. The scope of special action review is established by Rule 3 of the Arizona Rules of Procedure for Special Action, which reads in pertinent part:
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tion on some ground other than *Younger*, *e.g.*, abstention under *Railroad Commission v. Pullman Co.*, 312 U.S. 496, 61 S.Ct. 643, 85 L.Ed. 971 (1941), we have stated that the standard of review is one of abuse of discretion, with the discretion to "be exercised within the narrow and specific limits prescribed by the particular abstention doctine involved." *C-Y Development Co. v. City of Redlands*, 703 F.2d 375, 377 (9th Cir.1983) (quoting *Pue v. Sillas*, 632 F.2d 74, 78 (9th Cir.1980)). *See also Fresh International Corp.* at 1356 n. 2. In the case at bench, the district court abstained on the basis of *Younger*. No other abstention principle is involved. Our review, therefore, is de novo.

[3] Abstention from the exercise of federal jurisdiction is the exception, not the rule. *Colorado River Water Conservation District v. United States*, 424 U.S. 800, 96 S.Ct. 1236, 47 L.Ed.2d 483 (1976). Absent significant countervailing interests, the federal courts are obliged to exercise their jurisdiction. *Id.; County of Allegheny v. Frank Mashuda Co.*, 360 U.S. 185, 189, 79 S.Ct. 1060, 1063, 3 L.Ed.2d 1163 (1959). In *Younger v. Harris*, the Supreme Court held that federal courts should not enjoin pending state criminal proceedings except under extraordinary circumstances where the danger of irreparable loss is both great and immediate. 401 U.S. at 46, 91 S.Ct. at 751. *Id.* Three requirements have evolved for proper invocation of *Younger*: (1) ongoing state judicial proceedings; (2) implication of an important state interest in the proceedings; and (3) an adequate opportunity to raise federal questions in the proceedings. *Goldie's*, 739 F.2d at 469 (citing *Middlesex Ethics Committee v. Garden State Bar Association*, 457 U.S. 423, 432, 102 S.Ct. 2515, 2521, 73 L.Ed.2d 116 (1981)). Bad faith prosecution or harassment make abstention inappropriate even where these requirements are met. *Younger*, 401 U.S. at 47–49, 91 S.Ct. at 752–53. Similarly, satisfaction of the three requirements will not support abstention where a statute is flagrantly and patently violative of constitutional prohibitions. *Id.* at 53–54, 91 S.Ct. at 755–56.

1. Ongoing State Proceedings

[4, 5] At the time the district court abstained, World Famous had yet to appeal the adverse judgments in *World Famous II* and *World Famous III* to the state Supreme Court. Failure to exhaust state appellate remedies satisfies the requirement that there be "ongoing judicial proceedings" in order to justify federal abstention. *See Huffman v. Pursue, Ltd.*, 420 U.S. 592, 608–09, 95 S.Ct. 1200, 1210, 43 L.Ed.2d 482 (1975). A First Amendment challenge does not alter the propriety of abstention in such a case. *See Ohio Civil Rights Commission v. Dayton Christian Schools, Inc.*, — U.S. —, 106 S.Ct. 2718, 2724, 91 L.Ed.2d 512 (1986) (abstention proper where a First Amendment challenge may be raised in state court review of an administrative proceeding); *Huffman*, 420 U.S. at 612–13, 95 S.Ct. at 1212, 43 L.Ed.2d 482 (1975).

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[6] *Younger* abstention is not limited to ongoing state criminal proceedings, *see, e.g., Huffman*, 420 U.S. at 609, 95 S.Ct. at 1210. It extends to certain civil proceedings provided those proceedings implicate important state interests. *See Ohio Civil Rights Commission v. Dayton Christian Schools, Inc.*, — U.S. —, 106 S.Ct. 2718, 2724, 91 L.Ed.2d 512 (1986) (state civil rights enforcement proceedings); *Moore v. Sims*, 442 U.S. 415, 99 S.Ct. 2371, 60 L.Ed.2d 994 (1979) (temporary removal of child in child-abuse context); *Trainor v. Hernandez*, 431 U.S. 434, 97 S.Ct. 1911, 52 L.Ed.2d 486 (1977) (proceeding for recovery of fraudulently obtained welfare benefits); *Middlesex*, 423 U.S. at 432, 102 S.Ct. at 2521 (state bar discipline proceedings); *Huffman*, 420 U.S. at 605, 95 S.Ct. at 1208 (state nuisance proceeding akin to criminal prosecution). In evaluating whether the proceedings implicate important state interests, we examine the nature of the proceedings. The fact that the noncriminal proceedings closely relate to criminal proceedings, *see Huffman*, 420 U.S. at 604, 95 S.Ct. at 1208, or vindicate important state policies, *see Trainor*, 431 U.S. at 445, 97 S.Ct. at 1919, or are necessary for the

functioning of the state judicial system, *see Juidice v. Vail*, 430 U.S. 327, 336, 97 S.Ct. 1211, 1217, 51 L.Ed.2d 376 (1977), demonstrates an important state interest. *See Middlesex*, 457 U.S. at 431, 102 S.Ct. at 2520. In each of these cases, the state was a party to the proceedings. *See Miofsky v. Superior Court*, 703 F.2d 332, 337 (9th Cir.1983). *See also Worldwide Church of God, Inc. v. California*, 623 F.2d 613, 616 (9th Cir.1980) (state receivership order pursuant to investigation and regulation of fraud in charitable trusts), *cert. denied*, 449 U.S. 900, 101 S.Ct. 270, 66 L.Ed.2d 130 (1980); *Rosenthal v. Carr*, 614 F.2d 1219, 1220 (9th Cir.) (state bar disciplinary proceedings), *cert. denied* 447 U.S. 927, 100 S.Ct. 3024, 65 L.Ed.2d 1121 (1980).

[7] Here, Tempe brought a civil action in order to obtain compliance with an ordinance which aims at avoidance of public nuisances. It had the option of proceeding either by civil or criminal enforcement of its municipal ordinance; the option of criminal enforcement demonstrates the importance of the underlying state interest. *See Trainor*, 431 U.S. at 449–50, 97 S.Ct. at 1920–21 (Blackmun, J., concurring). Such an action, in aid of and closely related to Tempe's zoning ordinance and akin to a criminal prosecution, clearly involves an important state interest. *See Middlesex*, 457 U.S. at 434, 102 S.Ct. at 2522 (state bar disciplinary action); *Trainor*, 431 U.S. at 444, 97 S.Ct. at 1918 (civil proceeding brought to recover fraudulently obtained welfare payments); *Huffman*, 420 U.S. at 604, 95 S.Ct. at 1208 (public nuisance action). *Cf. Playtime Theatres, Inc. v. City of Renton*, 748 F.2d 527, 532–33 (9th Cir. 1984) (city's suit for declaratory relief not similar to criminal or "quasi-criminal" proceedings, nor did it involve interests vital to operation of state government), *rev'd on other grounds*, 475 U.S. 41, 106 S.Ct. 925, 89 L.Ed.2d 29 (1986); *Goldie's*, 739 F.2d at 469 (private unlawful detainer action does not implicate state interests); *Miofsky v. Superior Court*, 703 F.2d 332, 338 (9th Cir.1983) (private tort litigation does not implicate state interests). As such, the second requirement for the proper invocation of *Younger* abstention is satisfied.

3. Adequate Opportunity to Raise Federal Question

World Famous has failed to demonstrate how review of the adverse judgments in the state courts would not have permitted an opportunity to litigate its constitutional claims. That World Famous failed to avail itself of the opportunity to litigate its constitutional claim in the state forum, does not demonstrate that the state forum did not provide an opportunity to litigate that claim. *See Juidice v. Vail*, 430 U.S. 327, 337, 97 S.Ct. 1211, 1218, 51 L.Ed.2d 376 (1977). World Famous had an opportunity to pursue its constitutional claim upon appeal in the state courts,[4] and failed to do so. No more is required for *Younger* abstention. *See Ohio Civil Rights Commission*, 106 S.Ct. at 2724; *Moore*, 442 U.S. at 426, 99 S.Ct. at 2379; *Juidice*, 430 U.S. at 337, 97 S.Ct. at 1218.

Further, the record reveals no harassment or bad faith on the part of Tempe in bringing the civil enforcement and criminal proceedings which would make abstention improper. *See Huffman*, 420 U.S. at 611, 95 S.Ct., at 1211.

We hold abstention was proper and the merits of the constitutionality issue are not properly before this Court. *See Singleton v. Wulff*, 428 U.S. 106, 121, 96 S.Ct. 2868, 2877, 49 L.Ed.2d 826 (1976). *See also Huffman*, 420 U.S. at 602, 95 S.Ct. at 1207 (facial invalidity of statute is not exceptional circumstance justifying federal interference with state criminal proceedings) (citing *Younger*, 401 U.S. at 53–54, 91 S.Ct. at 754–55).

We also decline to consider World Famous' estoppel argument. World Famous

4. We note that the scope of review of a special action provides for consideration of "[w]hether the defendant has proceeded ... without or in excess of jurisdiction or legal authority." Ariz. Rev.Stat.Ann., Rules of Procedure for Special Actions 3 (1973). It appears that the state courts could construe municipal ordinances in light of federal constitutional law. *Cf. Ohio Civil Rights Committee*, 106 S.Ct. at 2724.

fails to provide us with a reason for its failure to raise the estoppel issue below. Nor is the estoppel determination one of law whose proper resolution is beyond any doubt, *see Telco Leasing, Inc. v. Transwestern Title Co.*, 630 F.2d 691, 693 (9th Cir.1980). Accordingly, the estoppel issue is not properly before us. *See Kline v. Johns-Manville*, 745 F.2d 1217, 1221 (9th Cir.1984); *Taylor v. Sentry Life Insurance Co.*, 729 F.2d 652, 665-56 (9th Cir.1984).

Affirmance makes unnecessary the consideration of Tempe's assertion that World Famous' action is precluded by the adverse determinations below.

AFFIRMED

KENNEDY, Circuit Judge, concurring:

General principles of abstention are distinct from the doctrine of dismissal for lack of jurisdiction pursuant to *Younger v. Harris*, 401 U.S. 37, 91 S.Ct. 746, 27 L.Ed.2d 669 (1971), and *Huffman v. Pursue Ltd.*, 420 U.S. 592, 95 S.Ct. 1200 (1975). Only the latter rule is applicable here, and *Huffman* squarely controls. I concur in the judgment.

APPENDIX H

CORRESPONDENCE BETWEEN AMICUS CURIAE AND COUNSEL OF RECORD FOR PETITIONERS AND RESPONDENTS.

(Reference: ***Motion for Leave to File an Amicus Curiae Brief, etc.,*** **. . . Page 1, fn. 1.)**

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(818) 352-2069
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February 16, 2000

Simon Heller, Esq. **Transmitted by Fax (letter only)**
Center for Reproductive Laws and Policy **(212) 514-5538**
120 Wall Street, 18TH Floor
New York, New York 10005

Re: ***Amicus Curiae*** Consent Request: ***Stenberg, Nebraska Attorney General v. Carhart***, on Writ of Certiorari to the U.S. Court of Appeals for the 8TH Circuit, No. 99-830.

Dear Mr. Heller;

Pursuant to **Rule 37(3)(a)** of the **U.S. Supreme Court Rules**, request is hereby made for your consent to the filing of a brief ***Amicus Curiae*** by myself as a member of the Bar of the U.S. Supreme Court, or by my client, ***Clarence Murphy***, in support of neither party in the above cause.

Clarence Murphy contends that ***Watson v. Buck***, 313 U.S. 387, 85 L.Ed. 1416, 61 S.Ct. 962, 136 A.L.R. 1426 (1941) and the ***Watson v. Buck*** **Abstention Doctrine**, as factored into the ***Huffman*** - ***Younger*** **Abstention Doctrines** is controlling and that the Federal Court lacks **Article 3, §2** (***Ex Parte Young***, 209 U.S. 123, 52 L.Ed. 714, 28 S.Ct. 441 [1908]) subject matter jurisdiction under the **11TH Amendment** and the ***Huffman*** - ***Younger*** **Abstention Doctrines**. The Trial Court record establishes that: **(1)** the Nebraska Attorney General is not acting as a "rogue" and the ***Ex Parte Young*** fiction to that

effect is dispelled; **(2)** the State of Nebraska has not waived its **11TH Amendment** lack of subject matter jurisdiction defense; **(3)** both statutes can be constitutionally construed by the Nebraska Judiciary; **(4)** the U.S. District Court has failed to make the factual findings required by ***Huffman*** **Abstention**; therefore it does not have **Article 3, §2** (***Ex Parte Young***) subject matter jurisdiction; **(5)** the Federal Civil Rights action must be dismissed for failure to state a federal claim because Carhart has an equivalent remedy in the Nebraska State Court; and **(6)** the 8TH Circuit Court of Appeals opinion is plain error, and therefore reversible, for the reasons state by Justice O'Connor in her concurring opinion in ***Brockett v. Spokane Arcades, Inc.***, 472 U.S. 491 at 507-511, 86 L.Ed.2d 394, 105 S.Ct. 2794 (1985).

Amicus Curiae proposes the following Jurisdictional Questions based upon the High Court's duty pursuant to ***Steel Co. v. Citizens for a Better Environment***, 523 U.S. 83, 140 L.Ed.2d 210, 118 S.Ct. 1003 (March 4, 1998) at **Point III**, to address the question of subject matter jurisdiction as the first order of business, and on its own motion if the parties to the lawsuit do not bring the matter to the trial court's attention:

I

Whether the U.S. District Court for the District of Nebraska Lacked **Article 3, §2** Subject Matter Jurisdiction of Respondent Carhart's Federal Civil Rights Action for Failure of the Trial Court to Make the Jurisdictional Findings of Fact Required by the **11TH Amendment** and ***Watson v. Buck***, 313 U.S. 387, 85 L.Ed. 1416, 61 S.Ct. 962, 136 A.L.R. 1426 (1941) and the ***Watson v. Buck*** **Abstention Doctrine**, as Factored into the ***Younger - Huffman*** **Abstention Doctrines** by this Court's Opinions in ***Younger v. Harris***, 401 U.S. 37, 27 L.Ed.2d 669, 91 S.Ct. 746 (1971)

and ***Huffman v. Pursue, Ltd.***, 420 U.S. 592, 43 L.Ed.2d 482, 95 S.Ct. 1200 (1975), Reh. Den., 421 U.S. 971, 44 L.Ed.2d 463, 95 S.Ct. 1969; Where the State Legislature Has Enacted Legislation Dealing with the Public Crime of Infanticide Which Is Engaged in under the Mantra of a Personal Right to an Abortion; and Where Such Legislation Is Not Unconstitutional on its Face and Can Be Constitutionally Construed by the Nebraska Judicial System Which, Pursuant to the **Doctrine of Separation of Powers**, Is under a Constitutional Duty to Give Such Legislation a Constitutional Construction **?**

II

Whether the Opinion and Judgment of the 8TH Circuit Court of Appeals Abridges the Sovereign Right of the State of Nebraska under the **10TH** and **11TH Amendments to the Federal Constitution** to Have New Legislation Involving "Important State Interests" (Both Civil and Criminal) Given an Initial Construction by the State Judiciary Which Has the Duty under the **Doctrine of Separation of Powers** and ***Watson v. Buck***, Supra, and the ***Watson v. Buck*** **Abstention Doctrine** as That Doctrine Has Been Factored into ***Younger v. Harris***, Supra, and ***Huffman v. Pursue, Ltd.***, Supra, and the ***Younger - Huffman*** **Abstention Doctrines**, to Construe Such Statutes in a Constitutional Manner Where Possible and Assist the State Legislature in its Efforts to Write a State Statute Which Will Meet the Standards of the Federal Court and the U.S. Constitution **?**

III

Whether the Opinion and Judgment of the 8TH Circuit Court of Appeals Abridges the Sovereign Right of the State of Nebraska under the **10TH** and **11TH Amendments to the U.S. Constitution**, as Construed by this Court in ***Watson v. Buck***, Supra, and the ***Watson v. Buck*** **Abstention Doctrine** as That Doctrine Has Been Factored into ***Younger v. Harris***, Supra, and ***Huffman v. Pursue, Ltd.***, Supra, and the ***Younger - Huffman*** **Abstention Doctrines**; Which Require That New Legislation (Civil and Criminal) Involving an "Important State Interest" Which Can Be Given a Constitutional Construction must Be Initially Construed and Applied by the Nebraska Judiciary; Which; under the **Doctrine of Separation of Powers** Is Required, Where Possible, to Give the State Statute a "Saving Construction" and Thereby Assist the Nebraska State Legislature in its Effort to Write a State Statute Which Will Meet the Constitutional Requirements of the Federal Judiciary with Respect to the Federal Constitution **?**

The arguments which ***Amicus Curiae Clarence Murphy*** will make in support of the above question are those set forth in the **Application for Leave of Court to File a Petition to Intervene Pursuant to F.R.C.P. 24(a)(2), and Petition for Writ of Mandamus, Pursuant to 28 U.S.C. §1651(a) in Excess of Applicable Page Limit** (113 pages) in ***In Re Murphy***, U.S.S.C.T. Misc. No. A-612, transmitted to the U.S. Supreme Court on January 23, 1999 and filed with the U.S. Supreme Court on March 10, 1999 as ***In Re Clarence Murphy***, No. 98-1442 (30 pages) and in the ***Motion for Leave to File an***

Amicus Curiae Brief, etc. in ***Pryor, et al. v. Summit Medical Association, et al.***, No. 99-1041, filed February 2, 2000 in the U.S. Supreme Court. Copies of the above documents were served upon you as Attorney of Record in ***Pryor, et al. v. Summit Medical Association, et al.***, supra.

Sincerely yours;
James J. Clancy
Attorney for Clarence Murphy.

JJC/cjc

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February 17, 2000

Hon. Donald Stenberg
Nebraska Attorney General
2115 State Capitol
Lincoln, Nebraska 68509

Transmitted by Fax (letter only)
(402) 471-3297

Re: ***Amicus Curiae*** Consent Request: ***Stenberg, Nebraska Attorney General v. Carhart***, on Writ of Certiorari to the U.S. Court of Appeals for the 8TH Circuit, No. 99-830.

Dear Mr. Stenberg;

Pursuant to **Rule 37(3)(a)** of the **U.S. Supreme Court Rules**, request is hereby made for your consent to the filing of a brief ***Amicus Curiae*** by myself as a member of the Bar of the U.S. Supreme Court, or by my client, ***Clarence Murphy***, in support of neither party in the above cause.

Clarence Murphy contends that ***Watson v. Buck***, 313 U.S. 387, 85 L.Ed. 1416, 61 S.Ct. 962, 136 A.L.R. 1426 (1941) and the ***Watson v. Buck*** **Abstention Doctrine**, as factored into the ***Huffman*** - ***Younger*** **Abstention Doctrines** is controlling and that the Federal Court lacks **Article 3, §2** (***Ex Parte Young***, 209 U.S. 123, 52 L.Ed. 714, 28 S.Ct. 441 [1908]) subject matter jurisdiction under the **11TH Amendment** and the ***Huffman*** - ***Younger*** **Abstention Doctrines**. The Trial Court record establishes that: **(1)** the Nebraska Attorney General is not acting as a "rogue" and the ***Ex Parte Young*** fiction to that effect is dispelled; **(2)** the State of Nebraska has not waived its

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Amicus Curiae proposes the following Jurisdictional Questions based upon the High Court's duty pursuant to ***Steel Co. v. Citizens for a Better Environment***, 523 U.S. 83, 140 L.Ed.2d 210, 118 S.Ct. 1003 (March 4, 1998) at **Point III**, to address the question of subject matter jurisdiction as the first order of business, and on its own motion if the parties to the lawsuit do not bring the matter to the trial court's attention:

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L.Ed.2d 482, 95 S.Ct. 1200 (1975), Reh. Den., 421 U.S. 971, 44 L.Ed.2d 463, 95 S.Ct. 1969; Where the State Legislature Has Enacted Legislation Dealing with the Public Crime of Infanticide Which Is Engaged in under the Mantra of a Personal Right to an Abortion; and Where Such Legislation Is Not Unconstitutional on its Face and Can Be Constitutionally Construed by the Nebraska Judicial System Which, Pursuant to the **Doctrine of Separation of Powers**, Is under a Constitutional Duty to Give Such Legislation a Constitutional Construction **?**

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U.S. Supreme Court (a copy of the ***Motion*** is being sent to you under separate cover by Priority Mail on this date [2/17/99]).

Sincerely yours;
James J. Clancy
Attorney for Clarence Murphy.

JJC/cjc

Encls.: (Sent under separate cover, by Priority Mail): ***Motion for Leave to File an Amicus Curiae Brief, etc.*** in ***Pryor, et al. v. Summit Medical Association, et al.***, U.S.S.C.T. No. 99-1041.

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February 17, 2000

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James J. Clancy
The Law Office of James J. Clancy
9055 La Tuna Canyon Road
La Tuna Canyon, CA 91352

Re: *Stenberg v. Carhart*, No. 99-830
Amicus Curiae Consent Request

Dear Mr. Clancy:

I received your request for consent in the above referenced matter. Respondent does not consent to the filing of an *Amicus Curiae* brief by you or your client, Clarence Murphy.

Please do not request consent again.

Sincerely,

Simon Heller

Simon Heller

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DON STENBERG
ATTORNEY GENERAL

STEVE GRASZ
LAURIE SMITH CAMP
DEPUTY ATTORNEYS GENERAL

February 18, 2000

James J. Clancy
9055 La Tuna Canyon Road
La Tuna Canyon, Ca 91352

Re: ***Stenberg v. Carhart***, No. 99-830

Dear Mr. Clancy:

Thank you for your interest in supporting the position of the State of Nebraska in the above-referenced case. Pursuant to our agreement with opposing counsel regarding mutual consent to a limited number of amicus briefs, we are not able to provide consent to your brief. We encourage you to file your brief along with the requisite motion for leave.

Sincerely,

DON STENBERG
Attorney General

Steve Grasz

Steve Grasz
Deputy Attorney General

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Mar 29 2000

No. 99-830

Supreme Court, U.S.
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MAR 29 2000
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IN THE

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska; GINA DUNNING, Director of Regulation and Licensure of the Nebraska Department of Health and Human Services, and CHARLES ANDREWS, M.D., Chief Medical Officer of the State of Nebraska,

Petitioners,

—v.—

LEROY H. CARHART, M.D.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF OF AMICI CURIAE SENATOR BARBARA BOXER AND REPRESENTATIVE NITA M. LOWEY AND OTHER MEMBERS OF CONGRESS IN SUPPORT OF RESPONDENT LEROY H. CARHART, M.D.

ROBERT LEWIN
KEVIN J. CURNIN
CLAUDE G. SZYFER
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Dated: March 29, 2000

BEST AVAILABLE COPY

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INTERESTS OF *AMICI CURIAE*[1]

Amici curiae are a bipartisan group of members of the United States Congress who share a concern for the continued integrity of a woman's right to decide, without unnecessary or arbitrary governmental interference, whether to continue or terminate a pregnancy. We believe that a woman's right to decide is implicit in our Nation's concept of liberty, as guaranteed by the Constitution. As a fundamental right deeply embedded in our society, it should be insulated from shifting political winds, such as those giving rise to a new breed of legislation, commonly known by the misleading political sobriquet "partial birth" abortion bans, one example of which is now before this Court. Legislation of this type plays havoc with the constitutional principles that infuse this Court's abortion rights precedents and, if upheld, would signal a retreat from the enduring and core principles set forth in *Roe v. Wade*. As *amici* have witnessed firsthand, sponsors of "partial birth" abortion bans have strayed from constitutional guidelines in order to cultivate anti-abortion sentiment. In so doing, as the overwhelming majority of Federal courts that have considered this issue have held, they have impermissibly interfered with the liberty interest of pregnant women. Like any law that is contrary to constitutional principles, the law now before this Court must be invalidated.[2]

---

[1] Pursuant to Rule 37.6 of the Supreme Court Rules, *amici curiae* disclose that no part of this brief was authored by counsel for a party in this action, nor did any person or entity make a monetary contribution to the preparation or submission of this brief. Petitioners and Respondent both consented to the filing of this brief, and letters of consent are on file with the Clerk of the Court.

[2] *Amici curiae* are listed in Appendix A.

SUMMARY OF ARGUMENT

No legislation that was seriously designed to comport with the law of the land regarding a woman's right to decide to terminate a pregnancy would attack that right in a manner that so brazenly abuses this Court's precedents. Built around a term—"partial birth" abortion—that is more a political slogan than a meaningful term of law or medicine, the Nebraska law before this Court is rife with constitutional deficiencies.

These deficiencies are deliberate. The real purpose of the Nebraska ban and others of its kind is not to regulate within the framework established by this Court's abortion rights precedents, but to pierce the core of a woman's right to choose. If bans such as Nebraska's are upheld, they will roll back the clock to the days before *Roe v. Wade* recognized that it was the woman's right, and not the State's, to make the intensely personal decision of whether to terminate a pregnancy and, by recognizing that liberty interest, allowed women to participate fully in the social and economic life of this Nation.

This Court has identified only two State interests important enough to justify restricting the liberty interest of pregnant women. One is promoting maternal health and safety; the other is protecting potential life. Neither interest is served here. Indeed, Nebraska does not even attempt to serve either interest. Without the justification of a legitimate State interest, the Nebraska ban is an unwarranted and unconstitutional intrusion into this protected realm.

The Nebraska ban also runs afoul of this Court's pronouncements regarding the critical significance of fetal viability to the constitutional framework. Before viability—and it is only pre-viability abortions that are at issue here—State regulations must not "unduly burden" a woman's right to

choose an abortion. Despite the clarity of this Court's precedent, the Nebraska ban ignores this demarcation and applies with equal force before and after viability. The result, for a woman seeking to terminate a pregnancy before viability, is an "undue burden." By banning safe procedures that are the most medically appropriate for some women, the Nebraska ban forces them to exercise their right to have an abortion before viability only if they expose themselves to a greater risk to their health.

Regardless of whether they are applied before or after viability, governmental restrictions on a woman's right to an abortion are unconstitutional unless they contain an exception for the life and health of the mother. At no stage of the pregnancy can the mother's life or health be made subordinate to that of her fetus. Yet the Nebraska ban, again in derogation of this Court's clear precedent, contains an unacceptably narrow exception to save the life of the mother, and none at all to preserve her health.

This Court ruled long ago that the difficult decision of whether to terminate a pregnancy cannot be made unilaterally by the State. The fundamental right of a woman to make this decision has been carefully balanced by this Court against State interests. The Nebraska ban drastically alters this careful balance, to the great detriment of women. As such, the District Court and Court of Appeals were correct in finding that law unconstitutional, and, we respectfully urge, should be affirmed.

I.

"PARTIAL BIRTH" ABORTION BANS STRIKE AT THE CORE PRINCIPLES OF *ROE v. WADE*

Nebraska's "partial birth" abortion ban, Neb. Rev. Stat. § 28-328(1), impermissibly, indeed dangerously, upsets the

careful balance struck by this Court between the fundamental liberty interest of pregnant women and countervailing State interests.

A. *Roe* Recognized A Constitutional Right To Choose

Personal liberty is a guarantee of the Constitution, and from that guarantee emanates a right to privacy.[3] Although not explicit in the Constitution, the right to privacy is well-recognized by this Court and deeply embedded in American society.[4] The guarantee of privacy protects rights that are "fundamental" or "implicit in the concept of ordered liberty" from arbitrary governmental interference.[5]

This Court first held almost thirty years ago, in *Roe v. Wade*, that the privacy right "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." 410 U.S. 113, 153 (1973). As *Roe* set forth, the right to choose follows from and is fully consistent with other fundamental liberty interests involving highly personal decisions about marriage, procreation, contraception, family relationships, and child rearing and education.[6] Having long recognized "that freedom of personal choice in matters of marriage and family life is one of the liberties protected by

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[3] *See, e.g., Roe v. Wade*, 410 U.S. 113, 152 (1973).

[4] *Id. See Poe v. Ullman*, 367 U.S. 497, 543 (1961).

[5] *Roe*, 410 U.S. at 152 (citing *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)).

[6] *City of Akron v. Akron Center For Reproductive Health, Inc.*, 462 U.S. 416, 427 (1983) ("The decision in Roe was based firmly on this long-recognized and essential element of personal liberty."). *See Skinner v. Oklahoma*, 316 U.S. 535 (1942) (procreation); *Prince v. Massachusetts*, 321 U.S. 158 (1944) (family relationships); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925) (child rearing and education); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (contraception); *Loving v. Virginia*, 388 U.S. 1 (1967) (marriage).

the Due Process Clause of the Fourteenth Amendment"[7]—including freedom of personal choice in matters "so fundamentally affecting a person as the decision whether to bear or beget a child"[8]—this Court in *Roe* found that the privacy right "necessarily includes the right of a woman to decide whether or not to terminate her pregnancy."[9]

Since *Roe*, this Court has repeatedly reaffirmed the Constitution's protection of a woman's right to choose. Most prominently, *Planned Parenthood v. Casey* reaffirmed that the decision to have an abortion "fits comfortably within the framework of the Court's prior decisions" regarding "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, [and] central to the liberty protected by the Fourteenth Amendment." 505 U.S. 833, 851 and 859 (1992). This right is now ingrained in our society.

B. Only Two State Interests Justify Restricting The Right To Choose

A woman's right to choose is not absolute. It can be weighed against two "important and legitimate" State interests: the health of the pregnant woman and the potential life of the fetus. *Roe*, 410 U.S. at 162; *Casey*, 505 U.S. at 846. If neither interest is served, however, State regulation in this protected realm is unwarranted and invalid.

Moreover, even if a legitimate State interest is served, it cannot be advanced in such a way as to render the right illusory, such that "choice exists in theory but not in fact." *Casey*, 505 U.S. at 872. Since *Roe*, this Court has therefore

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[7] *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 565 (1989) (Stevens, J., concurring in part and dissenting in part).

[8] *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

[9] *Webster*, 492 U.S. at 565.

crafted a careful balance between the protected liberty interest of pregnant women and the countervailing interests of the State. For "logical and biological" reasons,[10] the fulcrum of this balance is viability, when a fetus attains "the capability of meaningful life outside the mother's womb." *Roe*, 410 U.S. at 163.

The issue before this Court is the constitutionality of Nebraska's ban as applied before viability.[11] Before viability, the State interest in potential life of the fetus is not compelling.[11] The State therefore cannot attempt to protect fetal life in a manner that "imposes an undue burden" on the woman's right to terminate a nonviable fetus. *Casey*, 505 U.S. at 874. An undue burden has the purpose or effect of putting a "substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Id.* at 877. Indeed, "[t]he woman's right to terminate her pregnancy before viability is the most central principle of *Roe*." *Id.* at 871.

Throughout pregnancy, the mother's life and health are of paramount importance and cannot be compromised by the State regardless of the interest it purports to advance. Even after viability, when the State may prohibit abortion, it may not force a woman to continue a pregnancy that threatens her life or health. Moreover, it cannot require the woman who needs an abortion to undergo a method that is less safe for her in order to further fetal interests.[13] Because the life and health of the mother are unalterably superior to the State's

[10] *Colautti v. Franklin*, 439 U.S. 379, 386 (1979) (discussing *Roe*, 410 U.S. at 163).

[11] Respondent performs the disputed procedure only before viability. *See Carhart v. Stenberg*, 192 F.3d 1142, 1146 (8th Cir. 1999); *Carhart v. Stenberg*, 972 F. Supp. 2d 507, 511 (D. Neb. 1997).

[12] *See Roe*, 410 U.S. at 163-64; *Casey*, 505 U.S. at 846, 870.

[13] *See Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 769 (1986).

interest in the potential life she carries, abortion laws that do not contain an exception "to preserve the life or health of the mother" are unconstitutional. *Roe*, 410 U.S. at 164. *Accord Casey*, 505 U.S. at 879.

Faced with the profoundly difficult issues raised by the abortion debate, this Court, over the course of almost thirty years, has fashioned a careful balance, attuned to both individual liberty and governmental interests. This balance has preserved the essential holding of *Roe* from the shifting currents of political opinion. Today's "partial birth" abortion bans, riding the latest political current, would destroy this balance and the liberty interest it protects. Flouting precedent, bans such as Nebraska's and those debated in Congress sweep indiscriminately into this protected realm.[14] These bans ignore the critical importance of viability and subordinate maternal health in order to serve the illegitimate interest of promoting a political anti-abortion message.[15]

C. "Partial Birth" Abortion Bans Derogate *Roe*'s Essential Holding

1. The Ban Does Not Protect Fetal Life

While Nebraska may have a general interest in potential life even at the earliest stages of pregnancy, it "falls short of justifying any plenary override of individual liberty claims." *Casey*, 505 U.S. at 857. Before viability, therefore, abortion regulations may only "provide a reasonable framework for a woman to make a decision that has such profound and lasting meaning." *Id.* at 873. Provided they do not become a "substantial obstacle" to the woman's exercise of her right

[14] Congress has debated "partial birth" abortion bans since 1995. *See* S. 939, 104th Cong. (1995); H.R. 1833, 104th Cong. (1995); S. 6, 105th Cong. (1997); H.R. 929, 105th Cong. (1997); H.R. 1122, 105th Cong. (1997); S. 928, 106th Cong. (1999); S. 1692, 106th Cong. (1999); H.R. 3660, 106th Cong. (2000).

[15] *Webster*, 429 U.S. at 521.

to choose, "regulations which do no more than create a structural mechanism by which the State . . . may express profound respect for the life of the unborn are permitted." *Id.* at 877. In sum, regulations to protect a woman's pre-viable fetus must be "designed to persuade her to choose childbirth over abortion." *Id.* at 878.[16]

The Nebraska ban has nothing to do with protecting fetal life. "Partial birth" abortion bans do not express a preference for childbirth, do not attempt to dissuade a woman from choosing abortion, and do not "express profound respect for the life of the unborn." *Casey*, 505 U.S. at 877. These bans do not "provide a reasonable framework for a woman to make a decision." *Id.* at 873. The purported purpose is to deny pregnant women access to a type of broadly defined procedure, without disturbing access to other procedures that are equally effective for aborting a nonviable fetus. Unlike a waiting period or informed consent provision, banning a procedure that lawmakers find offensive cannot be justified as a "structural mechanism" designed to promote childbirth or discourage abortion. Indeed, contrary to the parameters set forth in *Casey*, the Nebraska ban provides no means for the State to inform the woman's choice or otherwise contribute anything to her decision-making process—other than possible intimidation of women and their physicians. *See Casey*, 505 U.S. at 877 ("[T]he means chosen by the State to further the interest in potential life must be calculated to inform the woman's choice, not hinder it."); *Hope Clinic v. Ryan*, 195 F.3d 857, 878 (7th Cir. 1999) (Posner, C.J., dissenting) (criticizing "partial birth" abortion bans that do not attempt to inform women but are likely to intimidate physicians).

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[16] Regulations upheld on this basis include waiting periods, informed consent, recordkeeping and reporting, and parental consent provisions. *Maher v. Roe*, 432 U.S. 464, 473-74 (1977).

Because the ban does not further Nebraska's interest in pre-viable life, its intrusion on the liberty interest of pregnant women cannot be justified on that basis.[17]

2. The Ban Does Not Promote Maternal Health

The second State interest important enough to justify regulating the right to choose is the health and safety of the woman seeking an abortion. *See Casey*, 505 U.S. at 878 ("As with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion."). This interest has been found to justify regulations regarding the qualifications and licensure of the person performing the abortion,[18] the licensure and type of facility where it is performed,[19] and recordkeeping.[20] No such interest is furthered by the Nebraska ban.

Nebraska does not even purport to promote maternal health or safety, nor could it, even if its ban only applied to the D&X procedure.[21] The D&X procedure was found by the trial court to be safer than other alternatives, including the most common alternative, the D&E procedure.[22] Of course, the Nebraska ban is no more justifiable if, given the most reasonable interpretation of "partial birth abortion," it is read to bar the D&E procedure as well.[23]

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[17] Nebraska already bans post-viability abortions. Neb. Rev. Stat. §§ 28-329, 332.

[18] *E.g.*, *Mazurek v. Armstrong*, 520 U.S. 968, 974-75 (1997).

[19] *E.g.*, *Roe*, 410 U.S. at 163.

[20] *E.g.*, *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 81 (1976).

[21] The term "D&E" when used herein refers to an abortion procedure known as "dilation and evacuation." The term "D&X" refers to a type of D&E abortion known as "dilation and extraction."

[22] The trial court's finding, *Carhart*, 972 F. Supp. at 525-27, was affirmed by the Court of Appeals at *Carhart*, 192 F.3d at 1146.

(footnote 23 appears on following page)

3. The Ban Lacks A Maternal Health Exception

A State can advance its interest in a viable fetus by regulating or even proscribing abortion, but only if an exception is made "where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Roe*, 410 U.S. at 164-65. *Accord Casey*, 505 U.S. at 846. Although it is a bedrock of this Court's abortion rights jurisprudence, maternal health is ignored by the Nebraska ban. *See Colautti*, 439 U.S. at 400 (invalidating for vagueness provision that failed to "clearly specify . . . that the woman's life and health must always prevail over the fetus' life and health when they conflict" and that raised "[s]erious ethical and constitutional difficulties" by failing clearly to inform a physician "to consider his duty to the patient to be paramount to his duty to the fetus"); *Thornburgh*, 476 U.S. at 771 (striking regulation that "evince[d] no intent to protect a woman whose life may be at risk").

Nebraska's narrow exception "to preserve the life of the mother" offers no protection against threats to maternal health. It is interesting to note that even in its pre-existing statute proscribing abortions after viability, when the state interest is at it peak, Nebraska's legislature did include the constitutionally required maternal health exception. Neb. Rev. Stat. §§ 28-329, 330. Omitting the same exception from the present ban, which amounts to a statement that a mother's health is less important to the State than that of a nonviable fetus, disregards the plain law of the land.[24] By taking

[23] *Hope Clinic*, 195 F.3d at 878 ("But as banning 'partial birth' abortions is not intended to improve the health of women (or anyone else for that matter), it cannot be defended as a health regulation.") (Posner, C.J., dissenting).

[24] Some advocates of "partial birth" abortion bans argue that a maternal health exception would be abused by physicians who interpret it too broadly. *See* 144 Cong. Rec. H6209 (July 23, 1998) (statement of Rep. Hyde). This argument is flawed for at least five reasons. First, it is hypocritical, coming as it does from the same advocates who, in other aspects of the abortion debate, rely upon and trust the judgment of physicians. *See* 144 Cong. Rec. H6198 (July 23, 1998) (statement of Rep. Smith regarding letter from AMA to Sen. Santorum). Second, it is "founded on suspicion . . . discloses a lack of confidence in the integrity of physicians . . . [and] is necessarily degrading to the conscientious physician, particularly the obstetrician . . . ." *Bolton*, 410 U.S. at 196. Third, by licensing physicians, the State recognizes them to be "capable of exercising acceptable clinical judgment," and for those who do not, other forms of State censure are readily available. *Id.* at 199. Fourth, this argument does nothing to excuse the failure to follow the clear precedent of this Court. Fifth, Nebraska, like many states, provides a health exception to its post-viability abortion ban, as well as latitude to the physician to choose the method of post-viability abortion most protective of the woman's life *and* health. Neb. Rev. Stat. §§ 28-329-32.

unnecessary chances with the mother's health, Nebraska puts a "substantial obstacle" in the path of a woman seeking to terminate her pregnancy.

D. Partial Birth Abortion Bans Undermine The Rule of Law, To The Great Detriment of Women and Society

The doctrine of stare decisis, which requires adherence to sound judicial precedent, is indispensable to our constitutional form of government.[25] Adherence to precedent gives meaning to the rule of law and protects against arbitrary governance.[26] It furthermore protects a citizenry that relies upon precedent to order their lives.[27]

[25] *See Hilton v. South Carolina Pub. Rs. Comm'n*, 502 U.S. 197 (1991); Powell, *Stare Decisis and Judicial Restraint*, 1991 Journal of Supreme Court History 13, 16; Cardozo, *The Nature of the Judicial Process*, 149 (1921) (both cited in *Casey*, 505 U.S. at 854).

[26] *See Patterson v. McLean Credit Union*, 491 U.S. 164, 172 (1989); *Welch v. Texas Dep't of Highways & Pub. Transp.*, 483 U.S. 468, 478-79 (1987); *Vasquez v. Hillery*, 474 U.S. 254, 265-66 (1986).

[27] *See Moragne v. States Marine Lines, Inc.*, 398 U.S. 375, 403 (1970); *Williams v. Florida*, 399 U.S. 78, 127 (1970) (Harlan, J., concurring in part and dissenting in part).

Eight years after *Casey* was decided, there is still "no evolution of legal principle [that] has left *Roe*'s doctrinal footings weaker than they were in 1973." *Casey*, 505 U.S. at 857. The central holding of *Roe*, the right of a woman to terminate her pregnancy before viability, remains a highly workable rule well-rooted in our constitutional and social firmament, its soundness relied upon by millions of American women. As such, the doctrine of stare decisis compels that *Roe*'s central holding not be disturbed.

The purpose behind the stare decisis doctrine is "especially compelling" in a case of the constitutional magnitude of *Roe*.[28] On only two occasions in its history has this Court "responded to national controversies" of comparable magnitude by reversing course and stating a new rule of law.[29] *Casey*, 505 U.S. at 861. Both decisions were predicated on a fundamental change in the facts and circumstances upon which the rejected precedent was based. *West Coast Hotel* rejected the theory of laissez-faire economics embraced in *Lochner v. New York*[30] because it "seemed unmistakable to most people" that that theory rested on "fundamentally false factual assumptions." *Id.* at 861-62. *Brown v. Board of Education* rejected the "separate but equal" rule of *Plessy v. Ferguson*[31] because "[s]ociety's understanding of the facts upon which a constitutional ruling was sought in 1954 was thus fundamentally different from the basis claimed for the decision in 1896." *Id.* at 863.

Contrary to the circumstances underlying *West Coast Hotel and Brown*, the facts underlying *Roe*'s essential holding are no different today than they were in 1973, and the

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28 *Akron*, 462 U.S. 416, 420 n.1 (1983).

29 *West Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937), and *Brown v. Board of Education*, 347 U.S. 483 (1954).

30 198 U.S. 45 (1905).

31 163 U.S. 537 (1896).

Court's "explanation for its decision" no less sound. *Casey*, 505 U.S. at 863. The wisdom of preventing the disenfranchisement of women from modern American society by recognizing their liberty interest in deciding for themselves whether to continue a pregnancy is, if anything, more evident and more compelling today than it was in 1973.[32] While laissez-faire economic theory, by the time of *Lochner*, was "recognized everywhere outside the Court to be dead,"[33] the idea that the equal participation of women in our economic and social life is for the good of the Nation is alive and well. The finding adopted by this Court in 1992 that "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives," *id.* at 856, is no less vital today.

To directly compromise, if not neutralize, that right in the manner intended by bans such as Nebraska's would not, as in *Brown*, confirm what American society has already recognized, but rather refute it, sending an incomprehensible and disruptive message about the rule of law and the role of women in our society.[34] For millions of Americans who have come to rely on the liberty interest recognized in *Roe* and undisturbed in at least twenty subsequent abortion rights rulings of this Court,[35] to now pierce its heart by upholding such unprincipled restrictions would exact a "terrible cost"

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32 *See Green v. United States*, 355 U.S. 184, 215 (1957) (Frankfurter, J., dissenting) (noting that the respect for precedent mandated by stare decisis demonstrates "the wisdom of this Court as an institution transcending the moment").

33 *Casey* 505 U.S. at 862 (quoting Justice Jackson, The Struggle for Judicial Supremacy, at 85 (1941)).

34 *See Frontiero v. Richardson*, 411 U.S. 677, 684 (1973) (deploring our Nation's "long and unfortunate history of sex discrimination").

35 *See* Appendix B.

and cause "profound and unnecessary damage to the Court's legitimacy, and to the Nation's commitment to the rule of law." *Id.* at 869.

II.

"PARTIAL BIRTH" ABORTION BANS UNDULY BURDEN THE RIGHT TO CHOOSE

A. "Partial Birth" Abortion Bans Create A "Significant Obstacle" For A Woman and Her Physician

1. Bans of Particular Pre-viability Procedures Have Never Been Upheld By This Court

To further its interest in maternal health, the State may, for example, regulate who performs the abortion procedure and in what kind of facility. To further its interest in potential life, the State may express its preference for childbirth. But this Court has not been willing to approve bans or restrictions on the performance of particular abortion procedures, finding that such regulations are not adequately related to either legitimate State interest. In each of three cases since *Roe* in which this Court reviewed regulation of particular procedures, the regulation was invalidated.

In *Planned Parenthood of Central Missouri v. Danforth*,[36] several provisions of a Missouri abortion law were reviewed, including one which banned the use of saline amniocentesis as an abortion procedure. The ban was challenged on the grounds that saline amniocentesis was not only the most common form of abortion after the first trimester but it was safer than the readily available alternatives. This Court agreed and invalidated the ban for several reasons.

First, it was important to "recognize the prevalence" of saline amniocentesis "as an accepted medical procedure in

[36] 428 U.S. 52 (1976).

this country." *Danforth*, 428 U.S. at 77. In addition, a broad "outright legislative prescription" had the effect of deterring development of other safe and effective methods. *Id.* Most importantly, the ban "force[d] a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." *Id.* at 79.[37]

Because the Nebraska ban, like other "partial birth" abortion bans, will have the practical effect of banning both D&X and D&E procedures, the latter being the most common second trimester technique in the United States today, and because the remaining alternatives will be less safe for the mother than those outlawed, it, too, is an unreasonable and arbitrary regulation that should be invalidated.

Colautti v. Franklin[38] addressed the constitutionality of a Pennsylvania regulation that restricted physician discretion by providing that "the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother." *Colautti*, 439 U.S. at 397. The record indicated that available techniques for maximizing fetal survival all "involved disadvantages from the perspective of the woman." *Id.* at 398. Then, as now, there was "disagreement among medical authorities about the relative merits and safety of different abortion procedures that may be used during the second trimester." *Id.* at 399. The regulation was declared unconstitutionally vague because it did not clearly allow the physician to put the life and health of the mother first, but instead left the door open to a "trade-off" between

[37] The wisdom, in this case as in *Danforth*, of preventing legislative bans from chilling medical progress is proven by the fact that saline amniocentesis abortion is now nearly non-existent, as safer methods have been allowed to develop. *See* II.A.4, *infra*.

[38] 439 U.S. 379 (1979).

maternal and fetal health that raised "serious ethical and constitutional difficulties." *Id.* at 400.

The regulation reviewed in *Thornburgh v. American College of Obstetricians and Gynecologists*[39] required physicians, after viability, to use the procedure most likely to preserve the life of the fetus unless doing so presented "significantly greater risk" to the life or health of the mother. *Thornburgh*, 476 U.S. at 747. The Court of Appeals for the Third Circuit had found that this provision forced an unconstitutional "trade-off" between maternal and fetal health. This Court affirmed, agreeing that the provision was "not susceptible to a construction that does not require the mother to bear an increased risk in order to save her viable fetus." *Id.* at 769.

The same deficiencies that rendered these provisions unconstitutional are manifest here. The Nebraska ban forces a "trade-off" of an even less rational sort, one in which the health of the mother is subordinated not for the sake of potential life, but for the sake of a judgment by the Nebraska legislature that one medical technique is less "moral" than another. As discussed below, the Nebraska ban also dangerously interferes with a physician's exercise of medical judgment. The result is a regulation that unconstitutionally burdens the right to choose.

2. These Bans Supplant Physicians' Best Medical Judgment

By regulating a liberty interest solely to express a moral judgment, Nebraska has intruded without justification into a realm of fundamental privacy protected by the Constitution. By banning a safe pre-viability abortion procedure, it has also unduly burdened that liberty interest. Preventing physicians from recommending what for some women would be the most *medically* appropriate procedure (regardless of

[39] 476 U.S. 747 (1986).

what Nebraska's legislators feel is most *morally* appropriate), puts a substantial obstacle in the path of a woman who decides to terminate her pregnancy before viability.

Deciding *whether* to have an abortion raises complex medical, social, familial, moral and religious questions. Deciding *how* to perform an abortion is primarily a medical question. This Court has repeatedly and unequivocally recognized how important it is to keep medical judgment, knowledge and skill free from unnecessary regulation.[40] Indeed, the right to choose recognized in *Roe* "vindicate[d] the right of the physician to administer medical treatment according to his professional judgment up to the point where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician." *Roe*, 410 U.S. at 165-66. Almost twenty years later, in *Casey*, this Court's recognition of the importance of safeguarding medical judgment from State impairment remained undiminished. There, for example, Pennsylvania's informed consent provision was upheld because it "d[id] not prevent the physician from exercising his or her medical judgment." *Casey*, 505 U.S. at 884.[41] From *Roe* to *Casey*, this Court has closely guarded against the potential for unnecessary State interference with a physician's judgment and ability most

[40] *See, e.g., Roe*, 410 U.S. at 165; *Danforth*, 428 U.S. at 61; *Thornburgh*, 476 U.S. at 764; *Casey*, 505 U.S. at 883-84; *Colautti*, 439 U.S. at 387 (*Roe* and *Bolton* "underscored the importance of affording the physician adequate discretion in the exercise of his medical judgment.").

[41] Even *Casey*'s approval of Pennsylvania's informed consent statute was tethered to that statute's recognition that the physician could tailor the required information where doing so was necessary to avert "serious adverse" consequences to the woman's health. *Casey*, 505 U.S. at 883-84.

safely to administer health care to women, particularly in performing pre-viability abortions.[42]

In *Doe v. Bolton*, for example, a regulation requiring the approval of a hospital committee before an abortion was performed was invalidated because "the woman's right to receive medical care in accordance with her licensed physician's best judgment and the physician's right to administer it are substantially limited." 410 U.S. 179, 197 (1973). The Court found that

> medical judgment may be exercised in light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman.

Id. at 192.

The State also may consider these factors, in addition to "the physical safety of a particular procedure," when crafting health regulations.[43] But that is not the purpose or effect of the Nebraska ban. Nebraska forbids a physician, directly responsible for preserving the pregnant woman's well-being

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[42] "The Court also has recognized, because abortion is a medical procedure, that the full vindication of the woman's fundamental right necessarily requires that her physician be given 'the room he needs to make his best medical judgment.' " *Akron*, 462 U.S. at 427 (quoting *Doe v. Bolton*, 410 U.S. 179, 192 (1973), and citing *Whalen v. Roe*, 429 U.S. 589, 604-05 n.33 (1977)). *See Colautti*, 439 U.S. at 387 (discussing importance of adequate physician discretion); *Danforth*, 428 U.S. at 67 n.8 (warning against "confin[ing] the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession").

[43] *See Akron*, 462 U.S. at 467 (O'Connor, J., dissenting).

and intimately involved in her right to choose, from offering her the pre-viability abortion procedure that carries the least risk to her health. *See Casey*, 505 U.S. at 895 ("The effect of state regulation of a woman's protected liberty is doubly deserving of scrutiny in such a case, as the State has touched not only upon the private sphere of family but upon the very bodily integrity of the pregnant woman.").[44] And the loss of the physician's judgment and attendant sacrifice of maternal safety is not offset by any legitimate gain for Nebraska, as there is no indication that any of the "health" factors that should inform a State's regulation in this area were even considered, much less served, by the Nebraska ban.

Perhaps it is because so much of their reasoning relies on the erroneous assumption that so-called "partial birth" abortion is *never* the safest pre-viability alternative, that advocates of such bans are willing to risk substituting their judgment for that of the attending physician *in every case*.[45] And yet, determining which procedure is safest for any particular woman 16 to 20 weeks pregnant is at least as complicated and individualized a medical question as determining when any particular fetus is viable, a question this Court has always held should be answered by the physician, not pre-ordained by the State.[46] The real risk here, of course,

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[44] *And see Casey*, 505 U.S. at 857 (discussing *Roe* as a rule of "personal autonomy and bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection," and citing, among other cases, *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 278 (1990).

[45] *See, e.g.*, 144 Cong. Rec. S.10511 (Sept. 17, 1998) (statement of Sen. Domenici) and S.10481 (statement of Sen. Faircloth).

[46] *See, e.g., Danforth*, 439 U.S. at 388-89. ("[W]e observed in *Roe* that viability is a matter of medical judgment, skill and technical ability, and . . . it is not the proper function of the legislature or courts to place viability, which essentially is a medical concept, at a specific point.")

is borne by the woman whose decision to terminate a nonviable fetus can only be effectuated if she subjects herself to a procedure that may be more dangerous to her life or health than the one outlawed. Regardless of how many or how few women are put at risk, replacing a physician's case-by-case judgment with a sweeping moral pronouncement is unduly burdensome. *See Casey*, 505 U.S. at 894 ("the proper focus is on the group for whom the law is a restriction, not the group for whom it is irrelevant"). *Accord Carhart*, 972 F. Supp. at 530 ("[F]or women who die or suffer serious complications because they cannot have the safest available procedure to abort their nonviable fetuses, the increased risk cannot be honestly considered insignificant.").

3. These Bans Make Exercising The Right To Choose More Dangerous

The right to choose has two identifiable components: deciding whether or not to have an abortion and, if made, implementing the decision to have an abortion.[47] After a decision to end a pre-viable pregnancy has been made, and the State's legitimate efforts, if any, to encourage childbirth have failed, "partial birth" abortion bans illegitimately interfere with the exercise of that choice by denying the woman, and her physician, access to what may be the safest and most medically appropriate procedure.

[47] *See Roe*, 410 U.S. at 164 (discussing "the abortion decision and its effectuation"); *Bolton*, 410 U.S. at 197 (discussing "[t]he woman's right to receive medical care . . . and the physician's right to administer it"); *Colautti*, 439 U.S. at 387 (discussing physician's central role "both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion [is] to be carried out"); *Akron*, 462 U.S. at 427 (discussing "full vindication of the woman's right" as necessitating exercise of medical judgment in "both assisting the woman in the decision making process and implementing her decision should she choose abortion").

Rather than create "a structural mechanism" that favors child birth, bans like Nebraska's effectively penalize the woman who decides against childbirth. The effect is an undue burden—a substantial obstacle placed by the State between the woman's decision and her ability to act most safely on that decision.[48]

As reaffirmed in *Casey*, part of *Roe*'s "essential holding" is "the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State." *Casey*, 505 U.S. at 846 (emphasis added). Thus, other than by the kind of governmental influence sanctioned in *Casey* (*e.g.*, "legislation aimed at ensuring a decision that is mature and informed," *id.* at 883), once a woman makes a decision to terminate a pre-viable fetus, that decision "may be effectuated by an abortion free of interference by the State." *Roe*, 410 U.S. at 163. *See Colautti*, 439 U.S. at 386 ("[P]rior to viability, the State may not seek to further this interest by directly restricting a woman's decision whether or not to terminate her pregnancy."). True, *Roe*'s "essential holding implies no limitation of the authority of

[48] There can be no doubt, based on the record before this Court, that the D&X procedure performed by Respondent is the safest for some women. The District Court so found on two occasions: in granting a preliminary injunction against the Nebraska ban, and after a full trial on the merits, in granting a permanent injunction. These findings of fact were not disturbed by the Court of Appeals.

Among the risks to maternal life and health that Respondent avoids by performing the D&X procedure are: (1) longer operating time; (2) greater blood loss and infection; (3) complications from bony fragments; (4) instrument-inflicted damage to the uterus and cervix; (5) exposure to the most common causes of maternal mortality (DIC and amniotic fluid embolus); [and] (6) "horrible complications" arising from retained fetal parts. *Carhart v. Stenberg*, 11 F. Supp. 2d. 1099, 1127 (D. Neb. 1998) ("These are substantial obstacles within the meaning of *Casey*."). The vast majority of lower courts agree that the D&X procedure has significant health and safety benefits. *See Hope Clinic*, 195 F.3d at 883 (collecting cases).

the State to make a value judgment favoring childbirth over abortion," *Maher*, 432 U.S. at 474, but if a pregnant woman rejects that State-sponsored value judgment, and opts instead to end her pregnancy before viability, *Roe* and *Casey* limit the authority of the State to put new and additional obstacles in her path, such as the denial of a safe and medically appropriate means of effectuating her decision.

4. "Partial Birth" Abortion Bans Will Also Impede Medical Progress

Since *Roe*, this Court has kept a watchful eye on medical advances when balancing State interests against personal liberty. Indeed, the shift from *Roe's* trimester framework to *Casey's* more fluid viability standard reflected a judicial appreciation of medical progress. *See Casey*, 505 U.S. at 860. In stark contrast, Nebraska's ban and others like it ignore the importance of advances in medicine, to the detriment of both this Court's careful constitutional balancing and the health of pregnant women.

The procedures targeted by the Nebraska ban play an important and evolving role in second trimester abortions.[49] Medical advances in these and other techniques have made it safer for women who choose to end their pregnancies at this stage. Such advances should be encouraged, not stymied by sweeping prohibitions. *See Danforth*, 428 U.S. at 78 (striking provision banning particular procedure because, in part, ban appeared to sweep in procedures "that may be developed in the future and may prove highly effective and completely safe"); *Colautti*, 439 U.S. at 387 ("We thus have left the point [of viability] flexible for anticipated advancements in medical skill."). Because the Nebraska ban criminalizes a broad and vaguely defined class of medical procedures, it will have a particularly chilling effect on

[49] *Carhart*, 972 F. Supp. at 515-16, 525-27 (discussing D&E and D&X procedures).

physicians who will steer well clear of its proscriptions in order to avoid being prosecuted as criminals. *See Hope Clinic*, 195 F.3d at 889 (noting the "*in terrorem* effect" of "partial birth" abortion).

The harm to women is therefore twofold: access to a safe procedure today is denied and the likelihood of developing an even safer procedure tomorrow is diminished.

B. "Partial Birth" Abortion Bans Sacrifice Constitutional Principle To Political Expediency

1. The Political History Of Such Bans Belies Their True Purpose

As shown above, the effect of "partial birth" abortion bans such as Nebraska's and those passed by Congress but vetoed by the President would be to overturn several core principles of *Roe v. Wade*, rendering a woman's constitutional right to choose virtually meaningless. But it is also quite clear that such a result is exactly what the sponsors of such bans intend. Although they now contend that "partial birth" bans are designed to outlaw only the D&X procedure (which even so construed would violate this Court's precedents), the political history of these bans reveal a far broader agenda.

The *amicus* brief submitted on behalf of Petitioners by members of Congress ("Petitioners' Congressional Brief"), such as Representatives Hyde and Canady, claims that the Nebraska ban targets the D&X procedure only. Such representations are contrary to the plain language of the Nebraska ban, prior statements made by many of these same legislators, and prior claims by brief's author, James Bopp, Jr.

For example, Mr. Canady, through Petitioners' Congressional Brief, now represents that "[t]he history of congressional efforts to ban PBA ["partial birth" abortion] shows that only a new procedure was targeted . . . known as intact dilation and extraction ("intact D&X")—not conventional

abortion methods." Petitioners' Congressional Brief at 1. This new claim reverses his prior position. In 1996, in a letter to House members that attempted to muster anti-abortion sentiment for a then-pending federal ban on "partial birth" abortions, Mr. Canady declared that

> H.R. 1833 [The 1995 Partial-Birth Abortion Ban Act] *does not ban "D&X"* or "brain suction" abortions. H.R. 1833 bans *any* "abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery."[50]

Similarly, during debate in 1997 concerning another pending "partial birth" abortion ban, H.R. 1122, Representative Hyde, speaking in favor of the bill, unleased the following broadside against *Roe v. Wade*, in which he accused this Court of "strip-mining" the Constitution.

> This great trajectory in our national experience, that of inclusion, has been shattered by *Roe v. Wade* and its progeny. By denying an entire class of human beings the protection of the laws, we have betrayed the best in our tradition. We have also put at risk every life which someone, some day, somehow might find inconvenient.
>
> . . .
>
> We cannot today repair all the damage done to our culture by *Roe v. Wade*. We cannot undo the injustice that has been done to 35 million tiny members of the human family who have been summarily killed since the Supreme Court, strip-mining the Constitution, discovered therein a fundamental right to abortion. . . .[51]

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[50] Letter from Rep. Canady, dated March 18, 1996 at Supp. Appendix Exh. 31 (emphasis added)

[51] 143 Cong. Rec. H1220 (March 20, 1997) (Statement of Rep. Hyde). In Senate debate, supporters of the ban also spoke of it in terms of undoing the "horrendous rule" of *Roe v. Wade*. *See* 144 Cong. Rec. S.10492 (Sept. 17, 1998) ("[O]ne of the most tragic and saddest days in our nation's history was the day the Supreme Court ruled in *Roe v. Wade* that unborn babies can legally be killed by their mothers. Each of us who has fought, heart and soul, to undo that damaging decision, understood so well on January 22, 1973, that we had yet to see what devastation would come of such a horrendous rule.") (statement of Sen. Helms).

Finally, James Bopp, Jr. is both the author of the Petitioners' Congressional Brief and the author of 1998 article on "partial birth" abortions. Petitioners' Congressional Brief draws heavily from the article, yet steers clear of statements therein in which Mr. Bopp states that the term "partial birth" abortion does not mean what Petitioner now says it means. When writing for this Court, Mr. Bopp claims that D&X is the "targeted procedure" of "partial birth" abortion bans, but when cultivating anti-*Roe* sentiment in his article, he acknowledges that "partial birth" abortion "has a clear legislative definition making it unique from intact D&E, intact D&X (the ACOG definition), and other procedures."[52]

In addition, the Nebraska ban, like its federal counterparts, invites prosecutors to set their targets beyond the D&X procedure. Predicated as they are on the vague and medically meaningless term "partial birth" abortion, such legislation is inherently suspect.[53] Yet efforts to define this term were rebuffed, since clarifying these statutes would have made it more difficult to use them as proxies for the right to choose in general, and more difficult to stir "anti-abortion fervor" through misleading characterizations of the D&X proce-

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[52] James Bopp, Jr., *Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence*, 14 Issues L. & Med. 3, 6 (1998).

[53] *See Carhart*, 11 F. Supp. 2d at 1131 ("The legislature elected to use nonmedical terms to describe surgical techniques and it must bear the consequences of that decision."). *Accord Carhart*, 192 F.3d at 1145 (finding that the term has "no fixed medical or legal content").

dure.[54] Vagueness, and the elasticity it offers for attacking the heart of *Roe* from various angles, are preferred.[55]

Nebraska's ban and its federal analogues suffer from grave and obvious constitutional infirmities beyond vagueness and overbreadth. Most striking, and in direct defiance of this Court's abortion rights decisions, is the lack of a maternal health exception. Another glaring deficiency is the failure to respect this Court's foundational distinction between pre-viability and post-viability abortions. The motivation behind such tactics is clear: sponsors of these bans will not allow principle or precedent to interfere with their attack of *Roe*.

Tellingly, these infirmities could have been readily cured by amendment. And although an amendment recognizing the viability distinction and providing a maternal health exception was offered in Congress, the House majority refused to allow the amendment to be debated on the floor.[56] Again, the message is clear: only legislation aimed at the heart of *Roe v. Wade* will suffice. In sum, the "peculiar and questionable character"[57] of such bans is symptomatic of an agenda other than what is presently represented to this Court and other than what this Court's precedents require.

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54 *Hope Clinic*, 195 F.3d at 879-80 (Posner, C.J., dissenting).

55 *See Id.* at 879 (Posner, C.J., dissenting) ("[T]here is no meaningful difference between the forbidden and the privileged practice. . . . We should consider therefore why any state would pass such a law.").

56 *See* H.R. 1032, 105th Cong. (1997) (the Hoyer-Greenwood amendment).

57 *Hope Clinic*, 195 F.3d at 878 (Posner, C.J., dissenting).

2. The Liberty Interest Of Pregnant Women Does Not Stop At The Cervix

Faced with the transparency of trying to pass off these bans as something that they are not, Representatives Hyde, Canady and others retreat to what is, if anything, an even less plausible argument. Since the constitutional principles of *Roe v. Wade* and the political purposes of such bans cannot co-exist, this alternative argument posits that *Roe* is not at issue at all, much less at stake. *Roe*, this argument goes, is about the "unborn," whereas this legislation is about the "partially born." Petitioners' Congressional Brief at 20.[58]

Petitioners' congressional *amici* urge that *Roe* is inapplicable to "partial birth" abortions because *Roe* only protects fetuses that are entirely within the uterus, not those which may have begun to move into the vagina. This Court, however, has never gerrymandered a woman's anatomy into different zones with different levels of constitutional protection. *Roe*'s protections do not end at the cervical os.

This Court's precedents are therefore not susceptible to Petitioners' strained interpretation. The essential holding of *Roe*, reaffirmed in *Casey*, is that a woman has a right—one that is particularly resistant to State interference before viability—to determine whether to continue or terminate a pregnancy. *See Casey*, 505 U.S. at 871 ("The woman's right to terminate her pregnancy before viability is the most central principle of *Roe* [and] a rule of law and a component of liberty we cannot renounce."). The D&X procedure is a safe means of effectuating a choice that every woman has a right

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58 The Court of Appeals dismissed this argument as "unavailing." *Carhart*, 192 F.3d at 1151. Representatives Canady, *et al.*, base this argument in part on a regulation of the Texas Code that was not before the Court in *Roe v. Wade*. Yet Petitioner somehow extrapolates that this Court not only upheld the constitutionality of the regulation, but created a two-tiered analysis with different results for fetuses which are "unborn" and those which are "partially born."

to make. At the very least, bans like Nebraska's restrict a woman's ability to exercise her liberty and thus directly implicate *Roe*. Furthermore, the right to abortion has been expressed by this Court in terms of a careful balance between individual liberty and State interest. Because "partial birth" bans fundamentally disrupt that balance, those precedents are at issue. And when the core concepts of viability and maternal health are compromised, revisiting the essential holding of *Roe* is inevitable. Thus, in addition to a lack of common sense, the "legal" argument put forward by Petitioners' congressional *amici* lacks any support in the law and should, we respectfully submit, be rejected.

CONCLUSION

Bans such as Nebraska's defy this Court's abortion rights jurisprudence. They serve no legitimate State interest, they compromise maternal health, and they apply indiscriminately to pre- and post-viability procedures alike. Such bans sacrifice constitutional principles to political opportunism, disturbing not only the careful balance wrought by this Court over almost thirty years, but the ability of women to participate fully in the social and economic life of the country. Rooted as it is in a fundamental privacy right guaranteed by the Constitution, the liberty interest of pregnant women should not, indeed must not, be so cavalierly undone. For these and all the reasons stated above, *amici curiae* respectfully submit that the decision of the Court of Appeals to invalidate the Nebraska ban be affirmed.

Respectfully Submitted,

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APPENDICES

Appendix A

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Rep. Brian Baird
Rep. John E. Baldacci
Rep. Tammy Baldwin
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Rep. Sam Farr
Rep. Chaka Fattah
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Rep. Joseph M. Hoeffel
Rep. Rush Holt
Rep. Steve Horn
Sen. Daniel Inouye
Sen. James M. Jeffords
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Rep. Mark Udall
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Rep. Henry A. Waxman
Rep. Anthony D. Weiner
Rep. Lynn C. Woolsey
Rep. Albert R. Wynn

Appendix B

Connecticut v. Menillo, 423 U.S. 9 (1975); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976); *Beal v. Doe*, 432 U.S. 438 (1977); *Maher v. Roe*, 432 U.S. 464 (1977); *Poelker v. Doe*, 432 U.S. 519 (1977); *Colautti v. Franklin*, 439 U.S. 379 (1979); *Bellotti v. Baird*, 443 U.S. 622 (1979); *Harris v. McRae*, 448 U.S. 297 (1980); *Williams v. Zbaraz*, 448 U.S. 358 (1980); *H.L. v. Matheson*, 450 U.S. 398 (1981); *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983); *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476 (1983); *Simopolous v. Virginia*, 462 U.S. 506 (1983); *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986); *Webster v. Reproductive Health Servs.*, 492 U.S. 490 (1989); *Hodgson v. Minnesota*, 497 U.S. 417 (1990); *Ohio v. Akron Center for Reproductive Health*, 462 U.S. 416 (1990); *Rust v. Sullivan*, 500 U.S. 173 (1991); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992); *Mazurek v. Armstrong*, 520 U.S. 968 (1997).

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No. 99-830

IN THE

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, GINA DUNNING, Director of Regulation and Licensure of the Nebraska Department of Health and Human Services, and CHARLES ANDREWS, M.D., Chief Medical Officer of the State of Nebraska,

Petitioners,

v.

LEROY H. CARHART, M.D.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF OF PLANNED PARENTHOOD OF WISCONSIN, FREDERIK F. BROEKHUIZEN, M.D., GARY T. PROHASKA, M.D., GAVIN JACOBSON, M.D., NEVILLE SENDER, M.D. AND THE PLANNED PARENTHOOD FEDERATION OF AMERICA, AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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DESCRIPTION AND INTEREST OF *AMICI*[1]

Amici Planned Parenthood of Wisconsin, Frederik F. Broekhuizen, M.D., Gary T. Prohaska, M.D., Gavin Jacobson, M.D., and Neville Sender, M.D. are plaintiffs in *Planned Parenthood of Wisconsin, et al. v. James E. Doyle, et al.* (*Doyle*), 44 F. Supp. 2d 975 (W.D. Wis. 1999), *vacated by Hope Clinic v. Ryan* (*Hope*), 195 F.3d 857 (7th Cir. 1999) (*en banc*), *stayed*, No. 99-A428 (Stevens, Circuit Justice Nov. 30, 1999), *pets. for cert. filed*, 68 U.S.L.W. 3461 (U.S. Jan. 10, 1999) (Nos. 99-1156) & 68 U.S.L.W. 3480 (U.S. Jan. 14, 1999) (No. 99-1177). The Seventh Circuit's decision in *Hope*, upholding bans on so-called "partial-birth" abortion from Wisconsin and Illinois, conflicts with the ruling of the Eighth Circuit — at issue here — striking down a similar Nebraska law. *Hope* contains an incomplete and misleading discussion of the factual record in *Doyle* pertaining to the question of the maternal health benefits of the dilation and extraction (D&X) method of abortion. The outcome of *Doyle* could be determined by the decision in this case; thus, these *amici* have an interest in assuring that a complete and accurate discussion of the *Doyle* record is available to this Court.

Amicus Planned Parenthood Federation of America (PPFA), a not-for-profit corporation organized in 1922, is the leading national voluntary health organization in the field of family planning. Currently, PPFA has 132 affiliates

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1. Pursuant to Sup. Ct . R. 37.6, *amici* state that no counsel for a party authored the brief, in whole or part, and no person or entity, other than the *amici*, made a monetary contribution to the preparation or submission of the brief. Pursuant to Sup. Ct. R. 37.3(a), the parties have consented to the filing of this brief. Letters of consent are being filed with the Court.

in 47 states and the District of Columbia, operating approximately 875 health centers. In addition, in many states, Planned Parenthood affiliates have separate organizations that provide them with public affairs and lobbying support at the state level. PPFA submits this brief on its own behalf, on behalf of its affiliates, and on behalf of the state public affairs offices. Many Planned Parenthood affiliates provide abortions that would be prohibited by "partial-birth" abortion statutes, and many of those affiliates have been plaintiffs in challenges to "partial-birth" abortion statutes enacted in other states. The decision in this case will also affect the outcome of many of the other pending challenges to "partial-birth" abortion statutes; thus PPFA and its affiliates have an interest in assuring that a complete and accurate discussion of the *Doyle* record is available to this Court.

SUMMARY OF ARGUMENT

The third section of the majority decision in *Hope* assumed that the Illinois and Wisconsin statutes could be construed to define precisely, and only ban, the D&X method of abortion.[2] Proceeding on that assumption, *Hope* addressed

2. As this Court is aware, *Hope* found that there were possible narrowing constructions of the Wisconsin and Illinois statutes that, in the view of the *Hope* majority, would have limited application of the statutes to a distinct method of abortion, the D&X. *Hope* directed that the statutes be allowed to go into effect subject to "precautionary injunctions." These "precautionary injunctions" were supposed to protect the ability of physicians in Wisconsin and Illinois to provide what *Hope* characterized as "normal" dilation and evacuation (D&E) abortions, while the state courts — through a series of what would have amounted to "test" prosecutions — attempted to define the boundary between "normal" abortions and the D&X.

(Cont'd)

the question of whether states could constitutionally ban the D&X, even pre-viability, and even without an exception to allow the D&X when it would preserve the woman's health. In addressing this question, *Hope* discussed the medical evidence adduced at the *Doyle* trial,[3] and purported to

Amici dispute whether "partial-birth" abortion statutes can be construed narrowly. However, we do not address that issue here because it will be addressed fully in the respondent's brief. *Amici* also dispute whether *Hope's* "precautionary injunction" invention was legally permissible or feasible in reality, given that the D&X is not really a distinct procedure, but rather is a variant or modified approach to the D&E. *See infra* at 7. The impracticality and impermissibility of the precautionary injunction is particularly dramatic in *Doyle*, because the Wisconsin statute carries a penalty of mandatory life imprisonment. *Hope*, at 889 (dissent). *See also Planned Parenthood v. Doyle Pet. for Cert.* ("*Doyle Pet. for Cert.*"), No. 99-1156 at 20-23 (docketed Jan. 10, 1999). However, since there is no precedent for such an injunction, and petitioner has not argued for such an injunction, *amici* will not address that issue here.

3. The *Hope* majority ignored the findings made by the district judge in the Illinois case, stating only that none of the plaintiffs there use the D&X or assert a desire to do so. 195 F.3d at 871. Ignoring the district court findings was not only legally wrong, *see Anderson v. Bessemer City North Carolina*, 470 U.S. 564 (1985), and *Hope*, 195 F.3d at 883 (Posner, C.J., dissenting), but also a way of avoiding inconvenient facts. The Illinois district court made findings describing the health and safety advantages of intact procedures, *Hope Clinic v. Ryan*, 995 F. Supp. 847, 857-61 (N.D. Ill. 1998), and two of the Illinois plaintiff-physicians attested that they personally had performed numerous abortions in which they had partially vaginally delivered an intact or largely intact and living fetus. *Hope Cert. Pet. App.*, No. 99-1152, at 153-54, ¶ 3; 190-92, ¶¶ 27-33. Moreover, one of the Illinois plaintiff-physicians uses the D&X method defined in the ACOG Policy Statement, *see infra* at 9, when medically appropriate, *Hope Cert. Pet. App.*,

(Cont'd)

evaluate that evidence under applicable constitutional standards.

In doing so, *Hope* significantly mischaracterized the medical evidence adduced in *Doyle*, and misstated the applicable constitutional standard. *Amici* submit this brief solely to address these two aspects of *Hope*. We do so, first, to provide this Court with a complete and accurate discussion of the medical evidence in *Doyle*, because this evidence demonstrates not only that there is no maternal health interest that would justify banning the D&X, but that the D&X is, for many women, a medically appropriate abortion method; and, second, to highlight *Hope*'s misstatement of the legal standard to be applied to these facts.[4]

(Cont'd)
No. 99-1152, at 136-38, ¶¶ 5-7, and another performs variants on that method, *Hope Cert. Pet. App.*, No. 99-1152, at 175-78, ¶ 3 (describing use of intact procedure for woman with leukemia-caused low platelet count in order to minimize risk of cervical laceration or uterine perforation).

4. *Amici* note that *Hope* found an interest in "moral considerations" sufficient to justify bans on "partial-birth" abortions. *Hope*, 195 F.3d at 875. Such an interest has never been sufficient to support a regulation of any constitutional right, and has been rejected as a legitimate interest for regulating abortion. *Doyle Pet. for Cert.* at 28. As petitioner has not asserted such an interest in this case, *amici* will not address that aspect of *Hope*.

ARGUMENT

THE RECORD BEFORE THE SEVENTH CIRCUIT DEMONSTRATES THAT THE D&X IS OFTEN THE SAFEST ABORTION APPROACH; THE RECORD DOES NOT DEMONSTRATE THAT A BAN ON THE D&X SERVES AN INTEREST IN MATERNAL HEALTH

Hope characterizes the D&X procedure as a "marginal" procedure, *Hope*, 195 F.3d at 874, that "lacks demonstrable health benefits," and "is never necessary from the perspective of the woman's health." *Id.* at 872. Further, *Hope* asserts that these conclusions were "not a seriously contested issue. None of the plaintiff physicians in [*Doyle*] testified to the contrary." *Id.*

Based on this characterization of the record, the Seventh Circuit ruled that "when state law offers many safe options [to obtain a pre-viability abortion] the regulation of an additional option does not produce an undue burden," *id.* at 871, even if the regulation lacks an exception to protect the woman's health because the requirement of such an exception is not "a universal rule." *Id.* The court in *Hope* concluded that "partial birth abortion laws do not pose hazards to maternal health," *id.* at 873, and that judicial interference with these laws "cannot be justified on the ground that the D&X procedure is necessary to protect women's health." *Id.*

Hope significantly mischaracterizes the facts developed at trial in *Doyle*, and misstates the applicable legal standard.

1. The Trial Record Demonstrates That the D&X Is Safer For Some Women.

The record developed in the district court contains an extensive stipulation of facts. *App.*[5] 438-460. In addition, five physicians testified for plaintiffs. They were the Chairman of Obstetrics & Gynecology at the Boston University School of Medicine and Director of Obstetrics & Gynecology at Boston Medical Center (Dr. Stubblefield), a Professor and past-Chair of the Department of Obstetrics and Gynecology at the University of Wisconsin Medical School's Clinical Campus (plaintiff Dr. Broekhuizen), the physician generally regarded as the most experienced practitioner of the D&X approach (Dr. Haskell), and two physicians (plaintiffs Dr. Christensen and Dr. Smith) who regularly provide abortions in outpatient clinics.

The stipulation establishes that during the first trimester, physicians use a method of abortion that primarily relies on suction to evacuate the uterus. *Id.* 443-44, ¶ 27. After the first trimester, physicians commonly use the dilation and evacuation (D&E) method, which involves grasping and extracting the fetus, and frequently involves dismemberment of the fetus as it is extracted. *Id.* 445, ¶¶ 35-37.[6] The

5. Citations to "App." refer to the Lodging Appendix filed with this brief.

6. We note that the Seventh Circuit's descriptions of the D&E are inconsistent on the question of where the dismemberment of the fetus occurs. In one place the opinion notes that "physicians performing a D&E sometimes do not complete the dismemberment inside the uterus, and some fear that this could lead the procedure to be characterized as a partial delivery under the statute." (Cont'd)

alternative method of abortion in the later second trimester is induction, an in-patient procedure that induces labor to cause the woman to expel the fetus. *App.* 451-52, ¶¶ 72-77.

During some D&Es, depending on the gestational age and size of the fetus and the response of the woman's cervix to the dilation process, the physician will extract the fetus entirely intact, or extract the fetus intact until the skull lodges at the cervix. In the latter situation, the physician will collapse or crush the skull to complete the delivery. *App.* 446-47, ¶¶ 42-46. These abortions could be deemed D&X abortions. The record is clear, however, that the medical profession regards the D&X as a variant — or one approach on a continuum of approaches — of the D&E; that there is no "codified" definition of D&X; and that physicians have varying understandings of exactly what constitutes a D&X. *App.* 334. *See also App.* 77, 131, 328-29. *Compare App.* 447, ¶ 47; 448-50, ¶¶ 62-65.

The stipulation also establishes that, regardless of method, physicians endeavor to conclude an abortion as quickly as possible; and that they attempt to minimize both the number of times and the distance instruments are inserted into the woman's uterus. These goals minimize time under anesthesia, loss of blood during the procedure, and the risk of cervical or uterine lacerations. *App.* 442, ¶ 21.

The witnesses explained that after approximately 18-20 weeks of pregnancy, dismemberment of the fetus becomes

(Cont'd)
Hope, 195 F.3d at 863. Elsewhere it remarks that during a D&E the physician "dismembers the fetus inside the uterus. . . ." *Id.* at 861. The latter statement is unsupported by the record and is medically inaccurate. The record shows that frequently the portion of the fetus to be disattached will be outside of the uterus before it is disattached. *App.* 24-25, 98-99, 127-28, 370.

more difficult and potentially traumatic to the woman because the fetus is larger, with stronger ligaments and harder bones. *App.* 10, 105, 346-47. In these situations, the D&X approach, which emphasizes attempting to extract the fetus intact, minimizes the risk of uterine or cervical lacerations, *App.* 10, 84-85, 356, because it eliminates or minimizes instrumentation in the woman's uterus, keeps any necessary instrumentation as low in the uterus (i.e., as close to the cervix) as possible, *App.* 26, 84-86, 412, and minimizes the risk of sharp bone fragments causing internal injuries. *App.* 10, 337. *See also App.* 446, ¶ 42. As one physician testified, the D&X approach is an "opportunit[y] . . . to provide an easier, less traumatic procedure for the woman and to . . . provide overall a safer procedure." *App.* 27-29.

The testimony also shows that sometimes an induction abortion does not proceed smoothly; patients labor and experience pain for extended periods of time, but do not expel the fetus. "So we've learned that it's necessary to intervene at some point, 24 to 30 hours, if the fetal expulsion has not occurred." *App.* 399-40; *see also App.* 84-85. These interventions are also necessary if the patient begins to bleed heavily or to develop an infection. If a patient is actively bleeding, the physician must evacuate the uterus in order to stop the bleeding; and if an infection develops, the longer the patient delays, "the worse her condition will become." *App.* 341. In these circumstances, completing the induction using one of the techniques used to complete a D&X "definitely [affords] a positive medical benefit," *id.*; it "is a potentially life-saving and certainly [a] health-saving maneuver." *Id.* at 342. If a physician was forced to wait for the complete expulsion of the fetus, that "would actually lead

to an increased risk of complications . . . it would be not . . . to the advantage of the patient." *App.* 86.[7]

All five physicians who testified for the plaintiffs testified that they had performed or set-out to perform abortions that the Seventh Circuit ruled could be constitutionally banned. All five testified to having done so when they believed that method was medically preferable for the particular patient involved based on, among other considerations, gestational age, the manner in which the fetus presents itself, the dilation achieved in relation to the size of the fetus, and the orientation of the uterus. *App.* 10-11, 20-21, 106, 129, 132-33, 173, 342-43.

Moreover, among the exhibits admitted into evidence in *Doyle* were:

- The American College of Obstetricians and Gynecologists' (ACOG) Statement on Intact Dilatation and Extraction (Jan. 12, 1997), which includes the conclusion that "for some women [the D&X procedure] may be the safest procedure." *See App.* 452-52.

- A Report of the Board of Trustees of the American Medical Association (AMA) stating that the D&X minimizes uterine or cervical perforation, and may be preferred for hydrocephalic fetuses and fetuses with other anomalies incompatible with life. *See App.* 452.

- A newly published medical textbook, Maureen Paul, M.D., et al., *Clinician's Guide to Medical and*

7. *See also App.* 15 (discussing medical risks to waiting for entrapped skull to pass cervix during D&E).

Surgical Abortion (1999), that discusses the procedure as one approach to surgical abortion after the first trimester.

- The text of the chapter "First and Second Trimester Abortion" from the medical text, David Nichols, M.D., et al., *Gynecologic, Obstetric, and Related Surgery*[8] (2d ed. 1999), that discusses the D&X as a variation of the D&E for abortions after 20 weeks of pregnancy.[9]

This cumulative evidence led the *Doyle* district court to make explicit findings of the medical benefits of the D&X. The district court found that the D&X is quicker and easier after 18 weeks from the first day of the woman's last menstrual period, and involves fewer insertions of instruments into the uterus. This results in a reduction in the amount of bleeding, the amount of time a patient is subject to anesthesia, and the risk of uterine perforation. *Doyle*, 44 F. Supp. 2d at 979.

Not only was there significant evidence in the record about the benefits of the D&X approach for many patients based on the manner in which the abortion proceeds, there was also detailed evidence about specific cases and specific medical circumstances in which the witness considered the D&X approach to be preferable for a patient based on the woman's health or a preexisting medical condition, or a fetal anomaly.

- Plaintiff Broekhuizen testified about three specific cases he had encountered within the preceding few

8. This text had not been published at the time of the *Doyle* trial; however, the text of the chapter was admitted into evidence.

9. *See also Hope*, at 882-85 (dissent).

years in which he began the procedure using the D&X approach because he believed it was the best approach from the perspective of his patients' health. In two of the three cases, the fetus spontaneously expelled during the procedure; in the third case, involving a severely hydrocephalic fetus, Broekhuizen completed a D&X procedure.[10] *App.* 79-83, 455, ¶¶ 104-05, 107-08 (describing three cases). He testified that in his practice involving high risk pregnancies, if he were denied access to the D&X approach, "[he] would find [him]self in more situations . . . where [his] only alternative would be to do a cesarean section or a hysterotomy, a major surgical procedure with increased morbidity and mortality for the mother." *App.* 110-11.

- Dr. Stubblefield, an expert witness, testified both about a specific case he had encountered where he also undertook the D&X approach because he believed it was the best approach from the perspective of his patient's health, and about medical situations generally where he believed the D&X could be the preferred approach. *See App.* 341-45 (discussing medical situations, generally) and *App.*

10. The district court dismissed this testimony by noting that in two of the three cases discussed by Broekhuizen the fetus delivered spontaneously without his having to collapse the skull, and by disagreeing with Broekhuizen's judgment about how to have proceeded in the third case. *Doyle*, 44 F. Supp. 2d at 981. This reasoning is not sustainable. The relevant facts are that in each case Broekhuizen made a rational professional judgment that the D&X was the medically preferable method to end the pregnancy and preserve his patient's health.

348-50 (describing actual case).[11] He testified that in these complicated circumstances, the D&X offers women a "positive medical benefit preserving the health, possibly preserving the life." *App.* 342.

- Dr. Haskell, also an expert witness, testified about three specific medical conditions — uterine scars, uterine fibroids, and didelphis or bilobe uterus — where he believed the D&X would be medically preferable from the perspective of the woman's health. *App.* 19 (describing medical situations).[12]

The majority in *Hope* ignored the district court's findings of the medical benefits of the D&X, and characterized plaintiffs' evidence as nothing more than "unelaborated avowals" that fails to "identify any concrete circumstance," and lacks "specifics." *Hope*, 195 F.3d at 872. But, as shown above, the plaintiffs' testimony was hardly unelaborated avowals. Rather, it was quite specific and concrete. Moreover, it was entirely consistent with the medical wisdom of the ACOG statement; there are circumstances where the D&X approach will be the best approach to protect a woman's health.[13]

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11. The district court opinion completely overlooks this testimony.

12. The district court opinion also completely overlooks this testimony.

13. The State of Wisconsin in its *amicus* brief in support of appellants, as did the district court, seeks to undermine the testimony of Drs. Broekhuizen and Stubblefield by pointing-out that neither of the hospital residency programs they supervise trains residents (Cont'd)

The Seventh Circuit also noted the district court's statements that no physician would testify "unequivocally" that the D&X is safer; that one plaintiff (Broekhuizen) testified that further study was desirable; that another plaintiff (Smith) testified that he had never encountered a situation where the D&X would be the best procedure; and that one of the plaintiffs' expert witnesses (Haskell) testified that the D&X was never medically necessary to save the life or preserve the health of the woman. *Hope*, 195 F.3d at 872.

The Seventh Circuit is correct that all of the witnesses agreed that a prospective, peer-reviewed comparison of D&X to alternative methods was desirable. But none of the plaintiffs' witnesses suggested that a criminal ban is necessary until such a study is done. And, it would certainly be unprecedented to use the criminal laws to prevent doctors from using newly developed medical techniques merely because they had not yet been subjected to peer-reviewed study. Indeed, Dr. Stubblefield, one of this country's leading researchers on abortion safety, characterized the available studies as "pretty good evidence" and "a good beginning."

(Cont'd)
in the D&X approach. *Amicus Br. of the State of Wisconsin* at 20 & 23; *Doyle*, 44 F. Supp. 2d at 980. Both physicians explained why this is so at trial. Resident are trained to perform D&Es only to 17 weeks. After that point, D&Es become more difficult and it is not reasonable to undertake to train residents in this more difficult procedure. *App.* 326. The D&X, "a briefer procedure . . .with less need for instrumentation within the uterus," is generally beneficial only at point later than 17 weeks. *App.* 342-43. However, a physician cannot undertake a D&X unless he is capable of converting to a D&E if necessary. *App.* 60-61. Thus, since the resident programs only provide D&Es to 17 weeks, they do not offer or train residents in the D&X.

App. 346-47.[14] Dr. Broekhuizen (who, like Dr. Stubblefield, was the Chair of a large medical center's OB/GYN Department) testified that he hoped for published peer-reviewed studies in the future, but he also testified that he was not "troubled" by the absence of peer-reviewed published studies and that he was comfortable basing his opinions and adjusting his practice based upon his personal experience and the available information. *App.* 100, 105-06. Further, he noted, "when it comes to new procedures there [are] always . . . a couple of years before one will find information in peer review journals." *App.* 100. *See also Planned Parenthood v. Doyle*, 162 F.3d 463, 468 (7th Cir. 1998). These statements are professional endorsement of the safety of the D&X, tempered by candid acknowledgment that further study is desirable. They are neither equivocal as to the safety of the D&X, nor do they support a ban of the procedure to protect maternal health.[15]

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14. Dr. Stubblefield also regarded the available studies as akin to peer-reviewed publications because they had been reviewed by a panel of their professional peers and chosen as sufficiently meritorious for presentation at a professional meeting. *App.* 428-29, 433.

15. The district court also cited the fact (which *amici* acknowledge) that physicians do not routinely use the D&X and more typically use the D&E as evidence of equivocal support for the procedure. *Doyle*, 44 F. Supp. 2d at 980. Plaintiffs make medical decisions on an individualized basis; as Dr. Haskell, who pioneered the D&X approach, testified: "I evaluate each patient on an individual basis. It depends on the amount of dilation that the woman has, her actual weeks of gestation, the presenting part, the size of the fetus, and a number of other factors go into the decision." *App.* 11. This is the essence of quality professional care, and is consistent with this Court's holdings that physicians must be given

(Cont'd)

The statement about Dr. Smith mischaracterizes his testimony and illustrates the danger of the lack of clarity concerning what is a D&X. *See supra* at 7. Dr. Smith, indeed, did testify that he had never encountered a situation where he thought that the D&X, *as defined by ACOG*, was medically preferable. *App.* 148. However, while he has never performed an abortion that exactly fit the ACOG definition of the D&X, *App.* 131, "many times" he has extracted a fetus intact until the head was at the cervix and then crushed the skull to complete the extraction because doing so was preferable for the patient. *App.* 128-29. *Hope* would allow the states to construe their statutes to include this method as among those banned. *Hope*, 195 F.3d at 861-62, 865. Thus, Dr. Smith has "many times" performed a D&X abortion which the *Hope* majority views as within the permissible reach of the Wisconsin statute.

The Seventh Circuit's reference to Dr. Haskell's statement that the D&X is never medically necessary exploits confusion about the precise meaning of that term, resulting in a mischaracterization of the record. Plaintiffs' witnesses all testified that, to a physician, the phrase "medically necessary" refers to a particular outcome, *e.g.*, it is medically necessary to terminate this pregnancy. They further testified, however, that, if medical necessity refers to the method that poses the least risk to the woman's health, then D&X is often medically necessary. *App.* 21. *See also App.* 25, 84, 106.

(Cont'd)
the room necessary to make individual determinations in order to preserve the health of each woman. *See infra* at 18. The fact that physicians proceed on a case-by-case basis, and thus do not routinely use the D&X cannot be fairly characterized as equivocation or a reason to justify banning that method of abortion in the instances when the physician does consider it preferable.

Although the *Hope* court did not discuss these "findings," the *Doyle* district court also discussed what it characterized as "risks" associated with the D&X approach: (a) delay of an additional 24 hours in order to achieve greater dilation; (b) the risks of ruptured membranes or infection that are created by the delay; and (c) the risk of future cervical incompetence posed by the greater dilation supposedly caused by the D&X. *Doyle*, 44 F. Supp. 2d at 979. None of these findings are supported by the record.[16]

On the question of delay in order to increase cervical dilation, the testimony showed that, in the ordinary course, "dilation determines the technique . . . technique does not determine dilation." *App.* 12. Women respond differently to the dilation process and fetuses often turn out to be smaller (or larger) than expected. *App.* 84-85,164. Thus, frequently, where there is more rapid dilation or a smaller fetus, there is the "opportunity," *App.* 12-13, to attempt an intact extraction or a D&X. Where there is not adequate dilation to attempt an intact extraction or a D&X, then the physician must make a decision, based on a variety of variables, whether to undertake a dismemberment D&E or to delay the procedure to obtain further dilation. *App.* 164-65, 84-85.

On the issue of infection, there simply was no testimony of such a risk. There was, however, ample testimony that

16. The Seventh Circuit cited two articles whose authors "believe the D&X procedure to be more hazardous." *Hope*, at 872. As the dissent points out, neither of these articles is a "scientific" article. One (Sprang and Neerhof) was in the nature of commentary in a section of the Journal of the American Medical Association captioned "controversies," and focuses on ethical issues. The other (Romer) is a non-medical paper written by a pro-life activist and focuses on saving rather than aborting viable fetuses. *Id.* at 884. We add that the latter article was not even part of the record.

the D&X poses no increased risk of infection. *App.* 21, 96, 107-08, 354.

On the issue of future cervical incompetence from increased dilation, the State's witness passingly mentioned that "older European literature" indicated a risk from increased cervical dilation of future cervical incompetence. *App.* 202. However, several other witnesses testified that there is no evidence of a risk to the cervix from increased dilation as currently done in the United States. They testified that broad studies[17] of the sequelae of abortion, which included D&Es using laminaria through about 20 weeks, have found no evidence of such a risk and they knew of no evidence to the contrary for later abortions. *App.* 354-55. *See also App.* 11-13, 89-90.

Hope simply mischaracterized the record in the Wisconsin case when it asserted that the issue of whether the D&X approach is ever preferable from the perspective of a woman's health was never seriously contested. To the contrary, the record demonstrates that the D&X approach is frequently medically preferable for women seeking abortions after approximately 18-20 weeks gestation because it poses fewer medical risks than the alternatives, and that the D&X is also medically preferable for women seeking abortions under complicated circumstances relating either to other health conditions or fetal anomalies.

17. Dr. Stubblefield has participated in some of these studies. *App.* 355.

2. The Applicable Legal Standard Requires the State To Establish That the Statute Is Necessary to Protect Maternal Health, and the Statute Must Allow Physicians the Room to Make Medical Judgments Based on the Particular Circumstances of the Individual Patient.

The majority in *Hope* held that when safe methods of abortion are legal, it is permissible to ban another method. *Hope*, at 871. The *Hope* majority also held that such a ban need not contain an exception to protect a woman's health because legislation can regulate procedure by procedure without allowing for "case-by-case 'health exception[s].' " *Id.* at 873. Further, *Hope* viewed the legal question before it as whether bans on the D&X method "pose hazards to maternal health," and whether "interference with the operation of the state laws can[not] be justified on the ground that the D&X procedure is necessary to protect women's health." *Id.* at 873.

These holdings ignore what the Tenth Circuit has correctly characterized as the "unifying thread" of this Court's abortion jurisprudence, *Jane L. v. Bangerter*, 61 F.3d 1493, 1504 (10th Cir. 1995), *rev'd in part on other grounds sub nom.*, *Leavitt v. Jane L.*, 518 U.S. 137 (1996), that in any abortion regulation a woman's health be paramount and that the physician be given the room he needs to exercise his professional judgment consistent with that mandate. *Thornburgh v. Am. College of Obstet. & Gyn.*, 476 U.S. 747, 768-69 (1986) ("maternal health [is] the physician's paramount consideration," and even post-viability, abortion restrictions cannot force a woman to "bear an increased medical risk"); *Colautti v. Franklin*, 439 U.S. 379, 387 (1979) (maternal health depends on physician discretion to "determin[e] how any abortion is carried out"); *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 427 (1983).

Instead, *Hope* indulges a blanket presumption that for all women in all circumstances — in spite of the voluminous testimony of five physicians to the contrary and the statements of both ACOG and the AMA — the D&X is never a safer or medically appropriate or medically necessary procedure. This nullifies the principle that is both rooted in this Court's jurisprudence, and that underlies the practice of medicine, that physicians must be accorded the discretion and room to make judgments according to individual evaluations of a particular patient's circumstances. As Dr. Broekhuizen, one of the plaintiffs, testified, no procedure is without risk, and different risks balance-out differently and lead to different decisions for different patients. *App.* 89-90. *Hope* substitutes instead a blanket medical judgment that it imposes on all women in all situations, and that it enforces by threat of sending the woman's physician to prison for the remainder of his life.

Further, in evaluating a previability ban on a method of abortion, the relevant question is not the one posed by *Hope:* namely, whether the ban is likely to *harm* the health of pregnant women. Consistent with this Court's precedent, the applicable question is whether the ban is necessary to *promote* the state's legitimate interest in women's health. *See Planned Parenthood v. Casey*, 505 U.S. 833, 878 (1992) (inquiry is whether the regulation "further[s] the health or safety of a woman seeking an abortion"); *Planned Parenthood v. Danforth*, 428 U.S. 52, 76 (1976) (determinative question is whether restriction " 'reasonably relates to the preservation and protection of maternal health.' ") (quoting *Roe v. Wade*, 410 U.S. 113, 163 (1973)).

The evidence in *Doyle* does not approach meeting that standard. At best, if a court were to regard Wisconsin's single witness as credible — a dubious conclusion[18] — the record would, from the perspective most charitable to the State, establish a professional disagreement about the advisability of the D&X method in some medical circumstances. This hardly meets the State's burden of establishing that the Act is necessary to protect maternal health. *Doe v. Bolton*, 410 U.S. 179, 195 (1973) ("State must show more than it has in order to prove" maternal health interest); *City of Akron*, 462 U.S. at 430-31 (regulations upheld only after "State met its burden of demonstrating" regulations furthered maternal health interest).[19]

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18. *See Hope*, 195 F.3d at 882-84 (dissent) (describing Wisconsin's sole witness as "the dubious Dr. Giles . . .").

19. *Cf. City of Richmond v. Crosson*, 488 U.S. 469, 494-95, 500 (1989) (discussing importance of "factual basis" and " 'strong basis in evidence' " for racial classifications); *Wittmer v. Peters*, 87 F.3d 916, 918 (7th Cir. 1996) (need to substantiate, not merely assert, need for racial classification).

CONCLUSION

Amici urge this Court to affirm the holding of the Eighth Circuit.

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IN THE
Supreme Court of the United States

DON STENBERG, Attorney General
of the State of Nebraska, *et al.*,
Petitioners,
v.
LEROY CARHART, M.D.,
Respondent.

**On Writ of Certiorari to the
United States Court of Appeals
for the Eighth Circuit**

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL WOMEN'S ASSOCIATION, NATIONAL ABORTION FEDERATION, PHYSICIANS FOR REPRODUCTIVE CHOICE AND HEALTH, AND AMERICAN NURSES ASSOCIATION IN SUPPORT OF RESPONDENT

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STATEMENT OF INTEREST OF *AMICI CURIAE*

The American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Women's Association ("AMWA"), the National Abortion Federation ("NAF"), Physicians for Reproductive Choice and Health ("PRCH"), and the American Nurses Association ("ANA") submit this brief *amici curiae* in support of Respondent.[1]

ACOG, a non-profit educational and professional organization founded in 1951, is the leading professional association of physicians who specialize in the health care of women. Its more than 40,000 members represent approximately 90% of all board-certified obstetricians and gynecologists practicing in the United States, and it is the body representing the vast majority of physicians affected by Nebraska's ban on "partial-birth abortion" (the "Act"). Its members, whatever their beliefs about abortion, share an interest in opposing laws that interfere with a physician's ability to exercise his or her best medical judgment to determine the appropriate care for each patient, and they believe that physicians must be able to use new techniques or vary recognized techniques in order to advance the development of safe, effective medical procedures. ACOG has appeared as *amicus* in seven other cases involving laws similar to the Act.

AMWA is a national organization of 10,000 women physicians and physicians-in-training, dedicated to promoting women's health and fostering the woman physician. Founded in 1915, AMWA has physician chapters in 35 states, including Nebraska, and student chapters in nearly all of the nation's 144 medical schools. AMWA

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[1] Pursuant to Rule 37.6, *amici* state that no counsel for a party authored any portion of this brief, and no person other than *amici* and their counsel made any monetary contribution to the preparation or submission of this brief. Letters of consent to the filing of this brief have been lodged with the Clerk of the Court pursuant to Rule 37.3.

strongly opposes legislation banning any method of abortion or other interference with decision-making appropriately left to the woman and her physician.

NAF, a private, non-profit organization founded in 1977, is the professional association of abortion providers in the United States and Canada. NAF's mission is to promote and enhance the quality of abortion services, ensuring that abortion remains safe, legal, and accessible. NAF publishes clinical practice guidelines for abortion, publishes a leading textbook on abortion practice, and sponsors accredited continuing medical education programs for abortion providers. Its members include over 350 non-profit and private clinics, women's health centers, Planned Parenthood facilities and private physicians' offices in 46 states. NAF's members provide over half of the abortions performed in the United States each year and will thus be directly affected by the Act and similar laws in other states.

PRCH is a national, physician-led, non-profit organization founded in 1992. PRCH represents more than 3,500 physicians of various disciplines, and non-physician supporters. PRCH's mission is to enable concerned physicians to take a more active and visible role in support of voluntary universal reproductive healthcare. PRCH is committed to ensuring that all people have the knowledge, equal access to quality services, and freedom of choice to make their own reproductive health care decisions.

ANA is the only full-service professional organization representing the nation's 2.6 million registered nurses through its 53 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, and projecting a positive and realistic view of nursing. ANA is committed to ensuring the ready availability and accessibility of health

care services and has long supported freedom of choice and equitable access for all women to basic health services, including reproductive health care.

STATEMENT OF MEDICAL FACTS

The physician's main goal in performing any abortion is to terminate the pregnancy by the method safest for the woman.

1. First-Trimester Abortions [2]

The overwhelming majority of abortions in Nebraska —and nationwide—are performed in the first trimester of pregnancy.[3] In 1996, almost 90% of abortions occurred before 13 weeks LMP.[4] Virtually all first-trimester abortions are performed using a method known as vacuum aspiration (sometimes called suction curettage).[5] Vacuum aspiration is the safest surgical abortion procedure prac-

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[2] This discussion does not include early "medical" abortions—those performed by administering drugs (such as RU 486) to a pregnant woman to induce a miscarriage—which would not be banned by the Act. However, in the approximately 5% of cases in which a medical abortion fails, the pregnant woman would have to undergo a vacuum aspiration procedure.

[3] *See, e.g.*, Lisa M. Koonin et al., *Abortion Surveillance—United States, 1996, in CDC Surveillance Summaries*, 48 MORBIDITY AND MORTALITY WEEKLY REPORT (No. SS-4) 1, 25-26, 29 (Tables 6 & 8) (CDC, July 30, 1999).

[4] *Id.* Measuring the pregnancy in terms of "LMP" dates the length of the pregnancy from the first day of the woman's last menstrual period before she became pregnant. Fetal age measured by LMP is on average two weeks greater than if measured from the estimated date of conception.

[5] Koonin at 6; *see* A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION 107, 108 (Maureen Paul, et al. eds., 1999) ("CLINICIAN'S GUIDE"); Phillip G. Stubblefield, *First and Second Trimester Abortion, in* GYNECOLOGIC, OBSTETRIC, AND RELATED SURGERY 1033, 1033 (David H. Nichols & Daniel L. Clarke-Pearson eds., 2d ed. 2000).

ticed today.[6] It is generally used for abortions up to 14 weeks LMP.[7]

In a vacuum aspiration procedure, the physician dilates the cervix and inserts a small tube called a cannula through the vagina and cervix and into the uterus. Once the cannula is in the uterus, the physician creates negative pressure and delivers the products of conception. A single pass or several passes of the cannula through the uterus may be required before all the products of conception have been removed. The embryo or fetus may come through the cannula intact or disarticulated, and a portion of the fetus may enter the vagina while the fetus is still alive. Later in the first trimester, if the physician cannot complete the procedure with the cannula, rigid curettage or forceps may be necessary to remove the products of conception completely.[8]

2. Post-First-Trimester Abortions

In the second trimester of pregnancy (roughly 13-26 weeks LMP), when vacuum aspiration is no longer effective, dilatation and evacuation ("D&E"), and induction to a much lesser extent, are the most commonly used abortion procedures.[9]

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6 *See* CLINICIAN'S GUIDE at 108-09; Herschel W. Lawson et al., *Abortion Mortality, United States, 1972 Through 1987*, 171 AM. J. OBSTETRICS & GYNECOLOGY 1365, 1367-68 (Tables II & III) (1994); Willard Cates, Jr. & David A. Grimes, *Morbidity and Mortality of Abortion in the United States, in* ABORTION AND STERILIZATION: MEDICAL AND SOCIAL ASPECTS 155, 161 (Jane E. Hodgson ed., 1981).

7 *See generally* Pak Chung Ho, *Termination of Pregnancy Between 9 and 14 Weeks, in* MODERN METHODS OF INDUCING ABORTION 54, 56-57 (1995); CLINICIAN'S GUIDE at 109.

8 *See* PHILIP D. DARNEY ET AL., PROTOCOLS FOR OFFICE GYNECOLOGICAL SURGERY 169-74 (1996); CLINICIAN'S GUIDE at 111-12; Stubblefield at 1035-37.

9 ACOG, Technical Bulletin 109, *Methods of Midtrimester Abortion* (1987); *see generally* Stubblefield at 1042-45; CLINICIAN'S GUIDE at 123.

Dilatation and Evacuation. D&E now accounts for over 90% of post-first-trimester abortions performed in the United States. *See* Koonin at 41 (Table 18). Although every physician's technique varies somewhat, in general the physician begins by dilating the cervix with laminaria, which slowly expand by absorbing moisture from the woman's cervix and thus increase the circumference of its opening (or os). Laminaria are inserted hours to days prior to the evacuation portion of the procedure. The amount of time required for adequate dilatation varies based on a number of factors including the gestational age of the fetus and the number of prior vaginal deliveries.

After the cervix is sufficiently dilated, the patient returns to the physician to undergo the evacuation procedure, which lasts 10 to 30 minutes.[10] The physician begins by rupturing the membranes and suctioning out the amniotic fluid. Then a clamp or forceps is inserted through the dilated cervix. Using the instrument, the physician reaches into the uterus, grasps the fetus and attempts extraction. The physician does this by pulling the fetal part he or she has grasped in the instrument through the cervical os and into the vagina. At this point the fetus is usually intact. Often, especially earlier in the second trimester, disarticulation occurs after a fetal part has been brought into the vagina—as it does in Dr. Carhart's practice, *Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1103 (D. Neb. 1998), *aff'd*, 192 F.3d 1142 (8th Cir. 1999)—due to the counterpressure exerted as the rest of the fetus lodges against the uterine wall. Continuing disarticulation of fetal parts eventually kills the fetus. In some D&Es, little or no disarticulation occurs, and the physician removes the fetus relatively intact.

Especially later in the second trimester, the head of the fetus, its largest part, will generally be too big to fit

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10 For a more extensive description of the evacuation process, *see generally* EUGENE GLICK, SURGICAL ABORTION 48-57 (1998); DARNEY at 198-207; Stubblefield at 1042-44; CLINICIAN'S GUIDE at 127-36.

through the cervix because cervical dilatation is only about 20% of that achieved at term. In that case, the skull must be compressed to allow it to pass through the cervix. There are several ways to accomplish this, including using forceps or evacuating the contents with suction.

Intact D&E. Later in the second trimester, some physicians perform D&Es in which the fetus is delivered intact (known as "intact D&E"). In one variant, the physician brings the fetus through the cervix intact in a breech (feet- or buttocks-first) position up to the head and, if the head lodges in the uterus, collapses it to complete extraction. ACOG has referred to this procedure as intact dilatation and extraction ("intact D&X" or "D&X").[11] In another variant of intact D&E, the physician begins by collapsing the skull of a fetus that is presenting head-down and then delivers the fetus intact. Regardless of the presentation, such intact extractions constitute intact D&E procedures. Intact D&E, including D&X, is a minor—and often safer—variant of the "traditional" non-intact D&E.[12] It makes no medical difference whether any portion of the fetus is delivered before fetal demise.[13] An intact D&X may be the best or most appropriate procedure for a particular patient in a par-

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11 ACOG's description of this procedure is set forth in its *Statement on Intact Dilatation and Extraction* (Jan. 12, 1997) (*"ACOG Statement"*). ACOG attempted to define the procedure that was being discussed at the time in the highly charged political debate, congressional testimony, and in other publications. There is no medical or medical-ethical reason to distinguish among any of the variants of D&E.

12 *See generally* National Abortion Federation, *Second Trimester Abortion From Every Angle: Presentations, Bibliography & Related Materials* (1992) (*"NAF Bibliography"*); Stubblefield at 1043 (describing intact D&E as a "variation of D&E" and referring to "[t]he breech extraction variation of intact D&E").

13 *See* CLINICIAN'S GUIDE at 136-37; Stubblefield at 1043; Janet E. Gans Epner et al., *Late-term Abortion*, 280 JAMA 724, 726 (Aug. 26, 1998).

ticular circumstance.[14] Only the physician, in consultation with the patient and based on her circumstances, can make this decision.

Induction. Induction, or induced preterm labor, consists of "stimulating uterine contractions before the spontaneous onset of labor." ACOG, Practice Bulletin No. 10, *Induction of Labor* 1 (Nov. 1999) (*"Induction of Labor"*). This method accounts for only about 5% of post-first-trimester procedures nationally. Koonin at 41 (Table 18). The physician uses one of several substances and methods to induce labor, for example, prostaglandin in the form of vaginal suppositories or intramuscular injections; oxytocin as an intravenous injection; or some combination of saline, urea, and prostaglandin injected into the amniotic cavity. Although some of these substances may cause the death of the fetus, others do not. Rather, they initiate labor, which can last more than 24 hours and which usually, but not always, causes the death of a nonviable fetus.[15] In some cases in which the induction results in a breech delivery, the fetal skull may be too large to fit through the partially dilated cervix, in which case the physician generally collapses the skull (sometimes while the fetus still has a heartbeat) in order to complete the delivery. In other inductions, the umbilical cord may become entangled after the (still living)

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14 *See* Part II.B.1, *infra*. At least five federal courts have found that this procedure may be the safest one for women in the later part of the second trimester. *See Planned Parenthood v. Doyle*, 162 F.3d 463, 467-68 (7th Cir. 1998); *Carhart*, 11 F. Supp. 2d at 1107-08; *Hope Clinic v. Ryan*, 995 F. Supp. 847, 852 (N.D. Ill. 1998), *rev'd on other grounds*, 195 F.3d 857 (7th Cir. 1999); *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1070 (S.D. Ohio 1995), *aff'd on other grounds*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 118 S. Ct. 1347 (1998); *Evans v. Kelley*, 977 F. Supp. 1296, 1316 (E.D. Mich. 1997).

15 F. GARY CUNNINGHAM ET AL., WILLIAMS OBSTETRICS 599-600 (20th ed. 1997); *Induction of Labor* at 1; JAMES R. WOODS, JR. & JENNIFER L. ESPOSITO, PREGNANCY LOSS 59-61 (1987); CLINICIAN'S GUIDE at 139, 143 (Table 11-2).

fetus has been delivered into the vagina, requiring the physician to cut the cord (which kills the fetus) to complete the delivery.

Because induction requires around-the-clock medical attention, inductions take place in hospitals or hospital-level settings, thus greatly increasing expense and limiting accessibility. *See* Stubblefield at 1046; CLINICIAN'S GUIDE at 125. Some medical authorities indicate that induction often is unsuccessful prior to approximately 16 weeks LMP because the uterus is less responsive to the inducing agents. *See* PREGNANCY LOSS at 59; *Methods of Midtrimester Abortion* at 3; GLICK at 46-48. In the case of an incomplete or unsuccessful induction, a subsequent surgical abortion procedure is necessary. CLINICIAN'S GUIDE at 125. Induction poses risks to some women and may be absolutely contraindicated for others.[16]

Hysterotomy and Hysterectomy. Hysterotomy—a preterm cesarean section—is a radical procedure to terminate a pregnancy, WILLIAMS OBSTETRICS at 684-85; *Methods of Midtrimester Abortion* at 2, that was deemed "out of date" as an abortion technique fully 19 years ago.[17] Hysterotomy, a major surgical procedure, has all the risks of such surgery and is considerably riskier than either induction or D&E. *See, e.g.*, Gans Epner at 727 & Table

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16 For example, prostaglandins are contraindicated in patients with sepsis (blood infection), hypertension (high blood pressure), coronary artery disease, and, in some cases, asthma. CLINICIAN'S GUIDE at 125. Women with certain heart defects, such as defective heart valve, may not survive prolonged labor. *Id.* Inductions are also contraindicated for women who have had a previous hysterotomy or cesarean section with classical (vertical) scar because it can lead to uterine rupture, hemorrhage, and even death. *See* P. Boulout et al., *Late Vaginal Induced Abortion after a Previous Cesarean Birth: Potential for Uterine Rupture*, 36 GYNECOLOGIC & OBSTETRIC INVESTIGATION 87, 88 (1993); *Methods of Midtrimester Abortion* at 2.

17 P. Diggory, *Hysterotomy and Hysterectomy as Abortion Techniques, in* ABORTION AND STERILIZATION: MEDICAL AND SOCIAL ASPECTS 317, 331 (Jane E. Hodgson ed., 1981).

4. It is significantly more dangerous than a cesarean section done at term, because the uterine wall is thicker and tends to bleed more. It may also cause uterine rupture in subsequent pregnancies and may require the woman to have any subsequent delivery by cesarean section. Diggory at 317.

Hysterectomy, or the removal of the uterus, is not an appropriate method of abortion under any but the rarest circumstances. *See* Cates & Grimes at 161; Diggory at 321-24, 331. Hysterectomy leaves the woman sterile and has the potential to result in blood clots, severe infection, bleeding, or even death. ACOG, Patient Education Pamphlet, *Gynecologic Problems: Understanding Hysterectomy* (1995).

SUMMARY OF ARGUMENT

The Act—and others like it enacted throughout the country—is so hopelessly vague that the physicians subject to its terms cannot know what it prohibits. Reasonably read, it bans virtually all abortions in Nebraska, imperiling the public health by deterring physicians from providing their patients with medically appropriate and necessary care and imposing an unconstitutional burden on a woman's right to terminate her pregnancy.

Even if read to ban only intact D&X procedures, the Act cannot stand because it precludes some Nebraska women from obtaining the most medically appropriate abortion procedure for their particular health circumstances, and it thwarts medical advancement. The Act also lacks constitutionally compelled exceptions to protect women's health and lives.

ARGUMENT

I. THE ACT IS UNCONSTITUTIONALLY VAGUE.

Nebraska's ban on "partial-birth abortion" is hopelessly vague and therefore violates the due process rights of Dr. Carhart and his patients. *See, e.g., Colautti v. Frank-*

lin, 439 U.S. 379, 391 (1979). The Act's imprecise terms make it impossible for Dr. Carhart and similarly situated physicians to know which abortion procedures fall within the statutory ban. Contrary to the State's assertion that "no reasonable person" could interpret the Act as applying to D&E in addition to D&X (Brief of Petitioners ("Pet. Br.") 15), four reasonable federal judges —the District Court and the unanimous Court of Appeals—determined that the Act *unambiguously* bans D&E. *Carhart*, 11 F. Supp. 2d at 1120-21; 192 F.3d at 1146. At the very least, therefore, the Act is impermissibly vague because persons "of common intelligence must necessarily guess at its meaning and differ as to its application." *Smith v. Goguen*, 415 U.S. 566, 572 n.8 (1974) (citations omitted).

A. The Terms of the Act Are Hopelessly Ambiguous.

Neither the term "partial-birth abortion" nor the words used to define it provide meaningful guidance to physicians who must comply with the Act under the threat of felony prosecution and forfeiture of their medical licenses. The Act conditions liability on the performance of an abortion in which the physician "partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery." Neb. Rev. Stat. § 28-326(9). The Act then defines the phrase "partially delivers vaginally a living unborn child before killing the unborn child" to mean "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." *Id.*

This definition, however, could easily encompass virtually every safe and common abortion procedure. The phrase "partially delivers vaginally," for example, applies both when the physician partially delivers an intact fetus

into the vagina and when the physician delivers a portion of the fetus that is severed from the remainder, *see, e.g.*, *Planned Parenthood v. Miller*, 30 F. Supp. 2d 1157, 1165 (S.D. Iowa 1998), because "deliver" is a medical term of art meaning to remove the fetus, the placenta, or part of the fetus from the uterus.

The phrase "substantial portion" introduces still more vagueness. As the District Court properly found, based on the testimony of "[*e*]*very* doctor who testified," this term "could be interpreted in vastly different ways by fair-minded people." *Carhart*, 11 F. Supp. 2d at 1131 (emphasis added). Dr. Carhart understood "substantial portion" to refer to "any identifiable part of the fetus," including an extremity or a portion of the skull. *Id.* at 1118. Dr. Stubblefield testified that he had no idea how much of a fetus was a "substantial portion." *Id.* As for the State's experts, while Dr. Riegel surmised that "substantial portion . . . probably [referred to] over 50%" of the fetus, he readily conceded that "[i]t's a vague term." *Id.* Likewise, while Dr. Boehm interpreted the phrase as referring to "more than a hand or a leg," he acknowledged that "some people might consider a hand or a leg to be a substantial portion," and noted that his "own personal view" would not necessarily match that of "someone who wants to prosecute this letter of the law." *Id.* at 1119. As the District Court recognized, that is precisely why the statute is impermissibly vague. *Id.* at 1132.[18]

Finally, the Act's use of the phrase "living unborn child" further muddies the waters. "It is not clear whether 'living [unborn child]' refers only to an intact fetus with

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[18] *See also Richmond Med. Ctr. for Women v. Gilmore*, 183 F.3d 303, 305-06 (4th Cir. 1998) (Murnaghan, J., dissenting from order denying motion to vacate stay) (" 'substantial portion' [could] mean 'a portion of the trunk,' one-third of the fetus by volume, 'well into the thorax,' twenty-five percent, thirty-five percent, or a portion that is 'not insubstantial' "); *Rhode Island Med. Soc'y v. Whitehouse*, 66 F. Supp. 2d 288, 311 (D.R.I. 1999).

a heartbeat or some other form of 'life,' or to a disarticulated fetus with a heartbeat or some other sign of 'life.'" *Miller*, 30 F. Supp. 2d at 1165. The fact that the moment at which fetal demise occurs is "'extremely variable,'" *Carhart*, 11 F. Supp. 2d at 1118 (quoting testimony of Dr. Hodgson), further compromises a physician's ability to conform his or her conduct to the requirements of the Act.

B. The Act Potentially Reaches All Safe and Common Abortion Procedures and Is Not Readily Susceptible to the State's Proffered Narrowing Constructions.

The upshot of the Act's profound ambiguity is that D&E and other safe and common abortion procedures appear to fit within the statutory ban. The ban contains three essential elements: A physician must (1) deliberately and intentionally deliver into the vagina a living fetus or a substantial portion thereof (2) for the purpose of performing a procedure that the physician knows will kill the fetus and does kill the fetus (3) before completing the delivery. *See* Neb. Rev. Stat. § 28-326(9). These elements cannot be confined to the D&X procedure, as the State claims.

1. *The Act Reaches D&E and Other Safe and Common Abortion Procedures.*

As both the District Court and Court of Appeals recognized, the Act, reasonably interpreted, applies to D&E abortions. *See Carhart*, 11 F. Supp. 2d at 1128; 192 F.3d at 1150. In a D&E, as in any abortion procedure (other than a hysterotomy or a hysterectomy), the physician deliberately and intentionally "delivers" the (usually living) fetus or "a substantial portion thereof"—such as an arm or leg, *see Carhart*, 192 F.3d at 1150—into the vagina. *See Methods of Midtrimester Abortion; see also Planned Parenthood v. Woods*, 982 F. Supp. 1369, 1372 (D. Ariz. 1997). The physician generally delivers a presenting part of an intact fetus through the cervical os *before* any disarticulation occurs.[19]

D&Es also satisfy the second element of the statutory ban because the physician delivers a "substantial portion" of the fetus "for the purpose of performing a procedure that the physician knows will kill the fetus and does kill the fetus." By its nature, a D&E, like any abortion, is a procedure that the physician knows will kill the fetus and that contains intermediate steps that do kill the fetus. Thus, having delivered a "substantial portion" of a living fetus, the physician performing a D&E will then cause the death of the fetus—by disarticulating it, for example, or by collapsing its skull. A physician performing a D&E invariably satisfies the third element of the ban by then "completing the delivery."[20] Therefore, as the District Court and Court of Appeals held, D&E involves each

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[19] *See Carhart*, 11 F. Supp. 2d at 1104 ("the dismemberment occurs after [Dr. Carhart] pull[s] a part of the fetus through the cervix"); *id.* at 1128 & n.42; *Carhart*, 192 F.3d at 1147. In fact, disarticulation may not occur at all. When the physician pulls a substantial portion of the fetus through the cervical os, the fetus usually disarticulates as a result of traction at the cervix, but sometimes it does not. *See Carhart*, 11 F. Supp. 2d at 1107 & n.12. Indeed, it is sometimes predictable—given the amount of cervical dilatation and the position and gestational age of the fetus—that no disarticulation will occur. Thus, a physician doing a D&E may intentionally perform a procedure indistinguishable from a D&X. Ignoring this reality of abortion practice, the State proffers the mistaken theory that a bright line separates D&E from D&X. (*See* Pet. Br. 15-18.)

[20] The District Court found that "the fetus is 'invariably' alive" when Dr. Carhart begins performing a D&E, and Dr. Carhart "has observed fetal heart activity with 'extensive parts of the fetus removed.'" *Carhart*, 11 F. Supp. 2d at 1105. And while the moment at which fetal demise occurs during the performance of the D&E varies, *id.* at 1118, fetal demise generally occurs before the physician completes the delivery of the fetus. *See Carhart*, 192 F.3d at 1150. Dr. Carhart's D&E practice is fully consistent with the procedure described in medical texts. *See* CLINICIAN'S GUIDE at 135-37; Stubblefield at 1043.

of the required elements of a "partial-birth abortion." *Carhart*, 11 F. Supp. 2d at 1128-29; 192 F.3d at 1150.[21]

2. *Nothing in the Act's Text or Legislative History Supports the Limiting Constructions Advanced by the State and Its* Amici.

A court cannot reshape the Nebraska ban into something that applies only to D&X in order to save it, because the Act is not " 'readily susceptible' to such a construction." *Reno v. ACLU*, 521 U.S. 844, 884 (1997) (quoting *Virginia v. American Booksellers Ass'n*, 484 U.S. 383, 397 (1988)). A statute is not "readily susceptible" to a narrowing construction unless its "text or other source of [legislative] intent identifie[s] a clear line" for a court to draw. *Reno*, 521 U.S. at 884. As was true of the statute at issue in *Reno*, the Nebraska ban has "many ambiguities," *id.* at 870, and thus "provides no guidance whatever for limiting its coverage." *Id.* at 884.[22]

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[21] The Act's text also encompasses some induction and vacuum aspiration procedures. Inductions may entail partial delivery of a living fetus because "a portion of the fetus may come through the cervical os and into the vaginal cavity while the fetal heart is still beating." *Woods*, 982 F. Supp. at 1872; *see also Hope Clinic*, 995 F. Supp. at 857. In some inductions, such as those in which the fetal head becomes lodged in the woman's cervix or the umbilical cord becomes entangled, the physician takes steps after partial delivery that he or she knows will cause the death of the (then still-living) fetus before completion of the delivery. *See Hope Clinic*, 995 F. Supp. at 852. Likewise, in a vacuum aspiration procedure, a substantial portion of a living fetus—either intact or disarticulated—will be delivered into the cannula in the vagina. *See Carhart*, 11 F. Supp. 2d at 1103. The separation of the fetus from the placenta or disarticulation will cause its death shortly after it is brought into the vagina and before completion of the delivery. *See id.* at 1110. In these circumstances, the physician apparently will have performed a "partial-birth abortion." *See, e.g., Miller*, 30 F. Supp. 2d at 1165.

[22] *See American Booksellers*, 484 U.S. at 397 (court "will not rewrite a . . . law to conform it to constitutional requirements"). The notion that Nebraska's or any other "partial-birth abortion" ban applies only to the delivery of an "intact" fetus, *see, e.g., Richmond Med. Ctr. for Women v. Gilmore*, 144 F.3d 326, 328 (4th Cir. 1998) (Luttig, J., as single Circuit Judge), is without basis. Neither the Nebraska Act nor any similar legislation includes that term. In any event, as shown above (Part I.B.1, *supra*), the Act would still reach D&Es even if read to apply only to the delivery of a substantial portion of an *intact* fetus: In Dr. Carhart's practice and in general, D&Es regularly involve delivery of a substantial part of an intact living fetus into the vagina before any disarticulation occurs.

Contrary to the State's assertion (*see* Pet. Br. 27-28), the Act's "scienter" requirement does not create a safe harbor for D&E. Under Nebraska law, a person intends the natural and probable consequences of his actions. *See, e.g., State v. McDaniels*, 16 N.W.2d 164, 168 (Neb. 1944). It is a natural and probable consequence of performing a D&E that the physician will deliver a substantial portion of an intact fetus and then cause its death by disarticulating it or collapsing its skull. The physician will thus "deliberately and intentionally" have violated the Act.[23]

The State further distorts the Act in claiming that its text limits the ban to D&X abortions by requiring that the physician deliver a substantial portion of the fetus into the vagina for the purpose of performing a "*separate*, death-causing procedure." (Pet. Br. 14 (emphasis added).) This phrase appears nowhere in the Act. Contrary to the State's assertion that the "procedure" mentioned in the second sentence of the Act (the physician must perform "a procedure that [he] knows will kill the unborn child") must be "separate and distinct" from the "procedure" mentioned in the first sentence (*see id.* at 17), the word "procedure" appears to refer to the same thing—an abortion—in each sentence. *See Gustafson v. Alloyd Co.*, 513 U.S. 561, 570 (1995) ("identical words used in different

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[23] *See Carhart*, 11 F. Supp. 2d at 1129 ("a surgeon performing a routine D&E deliberately intends to do exactly what defendants admit is prohibited"); *see also Carhart*, 192 F.3d at 1150.

parts of the same act are intended to have the same meaning") (internal quotation marks and citation omitted).[24]

Even if the Act could be rewritten to include "separate" and "death-causing" before "procedure" in the second sentence of the Act, that construction would only compound the vagueness of the ban. There is no rational way to distinguish the "death-causing" portion of a D&X (the use of an instrument to decompress the fetal skull) from the "death-causing" portion of a non-intact D&E (the use of an instrument to disarticulate the fetus or collapse its skull, as is often necessary in a non-intact D&E). If the "death-causing" portion of the D&X is an independent "procedure," so too is the "death-causing" portion of the D&E; in each case the physician performs a distinct act that kills the fetus before completing the delivery.[25]

[24] Nor is there any basis for the State's assertion that the Act focuses on "*where* the killing act occurs." (Pet. Br. 17 (emphasis added).) Indeed, contrary to the State's suggestion that fetal death must occur in the vagina to come within the ban (*id.*), the fact that only a "substantial portion" of the fetus need enter the vagina —rather than the whole or even the bulk of the fetus—demonstrates that fetal death can just as readily occur in the uterus during a banned procedure (to the extent that it makes any sense at all to say death occurs either in the uterus or the vagina when a fetus is in both places at once). Even with a D&X, which the State asserts to be the sole object of the ban, fetal death does not "occur" in the vagina, because the decompression of the fetal skull—what the State identifies as the "death-causing" act (*id.* at 18)—takes place *in the uterus*.

[25] Some induction and vacuum aspiration abortions also appear to be covered by the Act even if a requirement that the physician perform a separate, death-producing act is read into the statute. If the fetal head becomes lodged at the cervix or the umbilical cord becomes entangled during induction, the physician may be required to take a step that causes fetal demise, thus bringing the procedure within the Act's ban. *See, e.g., Planned Parenthood v. Verniero*, 41 F. Supp. 2d 478, 485 (D.N.J. 1988); *Hope Clinic*, 995 F. Supp. at 852. In a vacuum aspiration procedure, the cannula may become clogged by an intact fetus; the physician then must remove the suction tube, which will cause the uterus to expel its contents into the vaginal cavity and, inevitably, result in fetal demise. *See*

Conversely, if the death-producing step within a D&E were seen as indivisible from the rest of that procedure (*see* Pet. Br. 17), then there is no reason why the death-producing step in a D&X should be seen as any more distinguishable from the balance of that procedure. These opposing applications of the State's logic—neither of which is any more compelling than the other—demonstrate that the Act as the State would rewrite it is no clearer than the version that appears in the statute books.

Nor does the Act's muddled legislative history support the proffered narrowing constructions. That the leading sponsor of the bill could not articulate a meaningful (much less a limiting) definition of "substantial portion"—and indeed opined that delivery of a foot *would* be covered by the Act—vividly illustrates the Act's vagueness. *See Carhart*, 11 F. Supp. 2d at 1131. Moreover, if the legislature really had intended to ban D&X but not D&E generally, it easily could have included some language to that effect in the Act. Indeed, the thrust of the *amici curiae* brief filed by medical professionals supporting the State is that D&X is widely recognized as a distinct medical procedure. *See* Brief of Association of American Physicians and Surgeons, *et al.* ("AAPS Br.") 5-12. The purported distinctness of the D&X procedure only underscores the significance of the State's failure to make any reference to it in the Act, whether by name or by reference to its well-established components.[26] Because the legislative history at best sends "inconsistent signals as to where the new line

Carhart, 11 F. Supp. 2d at 1108, 1110; CLINICIAN'S GUIDE at 112. This separate and deliberate act therefore would appear to violate the Act.

[26] In light of this complete failure to make reference to D&X, and the strong evidence that the ban covers D&E, the Seventh Circuit's admittedly "brute force" effort "to assimilate the statutory definitions [of "partial-birth abortion"] to the medical definition of D&X," *Hope Clinic*, 195 F.3d at 865, in this case would constitute an unreasonable departure from the text of the Act and its underlying purpose.

or lines should be drawn," accepting the State's narrowing construction would constitute "a serious invasion of the legislative domain." *Reno*, 521 U.S. at 544 (internal quotation marks and citation omitted).

II. THE ACT IMPOSES AN UNDUE BURDEN ON A WOMAN'S RIGHT TO SEEK AN ABORTION.

To the extent that the Act can be understood by physicians who perform abortions, its language, on its face, criminalizes safe and common abortion procedures used throughout pregnancy. It thus imposes an impermissible undue burden on a woman's right to terminate her pregnancy in violation of this Court's decision in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). By precluding a woman, in consultation with her physician, from choosing the most appropriate abortion procedure for her particular health circumstances, the Act places a substantial—and thus unconstitutional—obstacle in the path of a woman seeking an abortion.

A. The Act Prevents Women From Obtaining the Safest and Most Common Abortion Procedures Used Before Fetal Viability.

Whether read on its face or with the linguistic glosses urged by the State and the *amici* supporting it, the Act is so broad that it bans D&Es of all varieties, which account for more than 90% of post-first-trimester abortions performed in the United States, Koonin at 41 (Table 18), and 100% of Dr. Carhart's second-trimester practice, *Carhart*, 11 F. Supp. 2d at 1108-09. Because Dr. Carhart is the only provider of elective abortions after 16 weeks LMP in Nebraska, *id.* at 1102, D&Es account for nearly all abortions in the state performed between 16 and approximately 22 weeks LMP. Plainly, as the State implicitly concedes (Pet. Br. 23-28), a ban on D&Es constitutes an undue burden. *Cf. Planned Parenthood v. Danforth*, 428 U.S. 52, 79 (1976) (holding unconstitutional a ban on intra-uterine saline instillation, then the most common method of post-first-trimester abortion).[27]

Where, as here, the ban could prohibit not only D&Es, but also vacuum aspiration and induction procedures, *see* Part I.B.2, *supra*, the burden imposed by the Act is even more clearly undue. Because vacuum aspiration, induction, and D&E together account for more than 99% of abortions performed in Nebraska and in the United States, *see* Koonin at 29-30, 41 (Tables 8 & 18), such a ban is nearly absolute and unquestionably unconstitutional.

B. Even if Limited to the D&X Procedure, the Act Creates an Undue Burden Because It Unconstitutionally Forces Women From Safer to Riskier Abortion Procedures.

Even if the Act were somehow construed to proscribe only D&X, it would not pass constitutional muster. The unbroken tie that binds this Court's abortion cases is the preeminence accorded to women's health, which derives from the inescapable fact that pregnancy is fraught with health risks—including a risk of death, *see* Stubblefield at 1033—that the woman alone must bear. *See Casey*, 505 U.S. at 852. Thus, *Danforth* invalidated a ban on saline instillation abortions (which at the time left physicians with few alternatives other than hysterotomy and hysterectomy)

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[27] Forcing Dr. Carhart in all cases either to modify his current, safe D&E technique to avoid the reach of the Act by causing fetal demise *in utero* or to resort to induction abortions, a procedure that he does not now perform, would impose unacceptable health risks on his patients. *See Carhart*, 11 F. Supp. 2d at 1105-07; *see also* Stubblefield at 1046. Medical texts indicate that induction abortions are generally unavailable until 16 weeks LMP. *See* PREGNANCY LOSS at 59; *Methods of Midtrimester Abortion* at 3. The delay entailed in an across-the-board switch to induction would alone significantly and needlessly increase the health risks associated with the abortion. *See* Lawson at 1367 (Table II) (risks associated with abortion increase as gestation advances). Moreover, inductions are absolutely contraindicated for some women and relatively contraindicated for others. *See* note 16, *supra*.

because "as a practical matter, it forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." 428 U.S. at 78-79. *Colautti* again underscored the primacy of women's health by holding that a restriction on a physician's choice of abortion method that does not "clearly specify . . . that the woman's life and health must always prevail over the fetus' life and health when they conflict" raises "[s]erious ethical and constitutional difficulties." 439 U.S. at 400. And *Thornburgh* made clear that the state may not regulate abortion, including restricting a physician's choice of method, if it "fail[s] to require that maternal health be the physician's paramount consideration." *Thornburgh v. ACOG*, 476 U.S. 747, 768-69 (1986).

Casey did nothing to alter the weight this Court has always placed on maternal health in its analysis. Rather, *Casey* reaffirmed *Roe's* essential holding that—both pre- and post-viability—a state may not "interfere with a woman's choice to undergo an abortion procedure if continuing a pregnancy would constitute a threat to her health." 505 U.S. at 880, 846. A corollary to this holding is the principle that the state may not force a woman to terminate a pregnancy by a method less medically appropriate for her and may not deprive a woman of her right to choose among medically sound alternative methods of pregnancy termination. This, however, is precisely what the Act requires—even if read to ban only D&X.

1. *D&X Is a Safe Procedure, Within the Standard of Care, That Will Be the Most Medically Appropriate Procedure for Some Patients.*

Central to women's ability to protect their health interests is the ability of their physicians to exercise appropriate medical judgment. *See City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 427 (1982). "The choice of an appropriate abortion technique . . . is a complex medical judgment . . . ." *Colautti*, 439 U.S. at 401. On the basis of various factors—including the patient's

overall medical condition; the gestational age, size, and presentation of the fetus; the extent of dilatation of the cervix; the existence of fetal abnormalities; and a patient's desire, for example, to avoid prolonged labor and hospitalization—a physician, in consultation with his or her patient, chooses the most appropriate and safest abortion procedure for that particular patient at the time. *See* KENNETH E. NISWANDER & ARTHUR T. EVANS, MANUAL OF OBSTETRICS 15 (5th ed. 1996). The risk of a particular abortion procedure varies in every case, depending on the individual woman's health, the skill of the physician performing the procedure, the medical facilities available, and how the selected procedure proceeds on a given day. *See* CLINICIAN'S GUIDE at 125-26.

Depending on the physician's skill and experience, the D&X procedure can be the most appropriate abortion procedure for some women in some circumstances.[28] D&X presents a variety of potential safety advantages over other abortion procedures used during the same gestational period. Compared to D&Es involving dismemberment, D&X involves less risk of uterine perforation or cervical laceration because it requires the physician to make fewer passes into the uterus with sharp instruments and reduces the presence of sharp fetal bone fragments that can injure the uterus and cervix.[29] There is also considerable evi-

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[28] For example, as the District Court found, there are at least 10 to 20 Nebraska women each year for whom a D&X is the most appropriate procedure. *See Carhart*, 11 F. Supp. 2d at 1106, 1121-22, 1127.

[29] *See* CLINICIAN'S GUIDE at 135 ("When possible, intact delivery in pregnancies over 18 weeks reduces the number of instrument passes necessary for extraction."); *id.* at 136 ("The aim of intact D&E is to minimize instrumentation within the uterine cavity. . . ."). The testimony of experts on abortion practice overwhelmingly confirms this view. *See Evans*, 977 F. Supp. at 1296 (recounting testimony of six medical experts); *Voinovich*, 911 F. Supp. at 1069 (D&X "causes less trauma to the maternal tissues (by avoiding the break up of bones, and the possible laceration caused by their raw

dence that D&X reduces the risk of retained fetal tissue, a serious abortion complication that can cause maternal death, and that D&X reduces the incidence of a "free-floating" fetal head that can be difficult for a physician to grasp and remove and can thus cause maternal injury.[30] That D&X procedures usually take less time than other abortion methods used at a comparable stage of pregnancy can also have health advantages. The shorter the procedure, the less blood loss, trauma, and exposure to anesthesia.[31] The intuitive safety advantages of intact D&E are supported by clinical experience. *See* CLINICIAN'S GUIDE at 137-38.

Especially for women with particular health conditions, there is medical evidence that D&X may be safer than available alternatives. A select panel convened by ACOG concluded that D&X may be "the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman."[32] D&X may also be

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edges)"); *see also Carhart*, 11 F. Supp. 2d at 1107; *Whitehouse*, 66 F. Supp. 2d at 314; *Richmond Med. Ctr. for Women v. Gilmore*, 55 F. Supp. 2d 441, 455, 490 (E.D. Va. 1999); *Verniero*, 41 F. Supp. 2d at 485; *Miller*, 30 F. Supp. 2d at 1161; *Hope Clinic*, 995 F. Supp. at 851.

30 *See Carhart*, 11 F. Supp. 2d at 1107, 1123. Practitioners and medical experts confirm these potential advantages. *See Evans*, 977 F. Supp. at 1296; *Hope Clinic*, 995 F. Supp. at 851.

31 *See Richmond Med. Ctr.*, 55 F. Supp. 2d at 491; *Hope Clinic*, 995 F. Supp. at 852; *Voinovich*, 911 F. Supp. at 1069.

32 *ACOG Statement* at 2; *see also Voinovich*, 911 F. Supp. at 1067 (D&X may be most medically appropriate for women with prior uterine scar); *Evans*, 977 F. Supp. at 1296 (D&X is especially appropriate for women for whom induction is contraindicated). That ACOG "could identify no circumstances under which this procedure . . . would be the *only* option to save the life or preserve the health of the woman," *see ACOG Statement* at 2, is in no way inconsistent with the proposition that D&X may be the best or most appropriate procedure in certain circumstances. A single abortion procedure will virtually never be the *only* option to save the life or preserve the health of a woman, but it may be the *best* option.

the most appropriate abortion method in the presence of certain fetal indications. For example, D&X "may be especially useful in the presence of fetal abnormalities, such as hydrocephalus" because it entails reducing the size of the fetal skull "to allow a smaller diameter to pass through the cervix, thus reducing risk of cervical injury." David A. Grimes, *The Continuing Need for Late Abortions*, 280 JAMA 747, 748 (Aug. 26, 1998). In addition, "intactness allows unhampered evaluation of structural abnormalities" in the fetus and can thus aid in diagnosing fetal anomalies. CLINICIAN'S GUIDE at 136. Finally, an intact fetus can "aid . . . patients grieving a wanted pregnancy by providing the opportunity for a final act of bonding." *Id.*[33]

No reliable medical evidence supports the claims of the State's *amici* physicians that D&X endangers maternal health. These doctors claim (AAPS Br. 21-22) that the amount of cervical dilatation involved in D&X procedures can cause cervical incompetence. Many D&E procedures, however, involve similar amounts of dilatation—sometimes over a several-day period, *see* CLINICIAN'S GUIDE at 128; GLICK at 49—and of course childbirth involves even greater cervical dilatation. Their concern about the risks posed by internal podalic version, in which the physician repositions the fetus into a footling breech (AAPS Br. 22), is similiarly misplaced. Dr. Carhart "does not perform instrumental conversion of the fetus . . . but [rather] removes the fetus headfirst or feet first, depending on how the fetus is positioned." *Carhart*, 11 F. Supp. 2d at 1105.[34] Moreover, some clinicians recommend reposition-

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33 Some physicians also believe intact D&E is an easier procedure for physicians to master because it involves techniques that are more familiar to physicians than those involved in non-intact D&E. *See generally NAF Bibliography*; CLINICIAN'S GUIDE at 136.

34 There is nothing "self-contradictory" (AAPS Br. 16-17) about Dr. Carhart's belief that intact extraction is safer than dismemberment on the one hand, and his unwillingness to convert the fetus in

ing the fetus in some D&Es depending on how the fetus initially presents. *See* CLINICIAN'S GUIDE at 135. The "blind" procedure (piercing the fetal skull) that the *amici* physicians warn is so dangerous in a D&X (AAPS Br. 22-23) is arguably less blind than the continued use of sharp instruments in the uterine cavity that characterizes D&Es.[35] The State's (and its *amici* physicians') attempt to justify a ban on D&X as a protection of maternal health is clearly pretextual: The Act permits precisely the same procedure (with the same alleged risks to the woman) so long as the physician effects fetal demise *in utero* before any portion of the fetus is vaginally delivered.[36]

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order to perform a D&X on the other hand. First, the charge of inconsistency fails to recognize that Dr. Carhart performs intact D&Es, and thus realizes the safety advantages of intact extraction, when the fetus presents head-down, without the need for conversion. *See Carhart*, 11 F. Supp. 2d at 1105. Second, it is perfectly consistent for Dr. Carhart to conclude, given his assessment of his own skills and the relative risks involved, that the potential safety advantages of D&X are reduced (and even outweighed) when he must convert the fetus from a transverse or compound presentation. That conclusion, however, in no way undermines the determination that D&X is the safest procedure for Dr. Carhart's patients *when he can perform it*. Likewise, the relative infrequency of D&X in Dr. Car' .t's practice in no way refutes its safety advantages or argues against attempting it where appropriate.

[35] *See* CLINICIAN'S GUIDE at 133. Uterine perforation, which can require a bowel resection, colostomy, or hysterectomy, is the most serious complication of D&E and can be fatal. *See, e.g.*, Edward Trott et al., *Major Complications Associated with Termination of a Second Trimester Pregnancy: A Case Report*, 67 DEL. MED. J. 294, 296 (1995).

[36] The State's and its *amici* physicians' objection to D&X on the ground that it "blurs the line . . . between abortion and infanticide," by using obstetrical techniques to "perform[] an act quite contrary to the obstetrical role" (AAPS Br. 27; *see also* Pet. Br. 29), is equally misplaced. All abortion procedures use obstetrical techniques. Induction abortions in particular contain almost every element of delivery at term. *See Induction of Labor*. There is nothing unethical or medically inappropriate in employing obstetrical and gynecological techniques to terminate pregnancy in the

2. *A Ban Solely on D&X Cannot Withstand Constitutional Scrutiny.*

This Court has invalidated choice-of-method statutes that remove physician discretion and force women to resort to abortion procedures that are less safe or less appropriate for their particular health circumstances. *See Danforth*, 428 U.S. at 75-79; *Thornburgh*, 476 U.S. at 766-69. Underlying these holdings is the recognition that a constitutionally impermissible threat to women's health always results when the state removes a safe medical procedure from the physician's array of options. That other safe abortion procedures may remain available (Pet. Br. 33) does not eliminate the constitutional problem. Because the banned procedure will always be the safest for some (if not most) women, an absolute prohibition on a safe method of abortion will impermissibly increase the health risks of abortion for some women in some circumstances. The unbroken emphasis on maternal health in this Court's abortion jurisprudence precludes the state from restricting abortion in a manner that imposes such increased health risks. *See Casey*, 505 U.S. at 880.

The suggestion that a state may ban a safe abortion procedure so long as that procedure is not needed by a large number of women, *see Hope Clinic*, 195 F.3d at 871-74, betrays a misunderstanding of this Court's precedents. Rather, from this Court's command that women's health remain "paramount," *Thornburgh*, 476 U.S. at 769, and that every abortion restriction contain an exception to permit a woman to obtain an immediate abortion if continuing her pregnancy would constitute a threat to her health, *Casey*, 505 U.S. at 846, 880, it follows that a safe procedure that is within the standard of care must remain available for *each and every* woman for whom that procedure would be the most appropriate.

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manner safest for the patient and in keeping with the physician's role as a provider of comprehensive reproductive health services.

As the District Court found, even if the Act affected only the 10 to 20 women per year for whom Dr. Carhart performs a D&X, it would violate the constitutional rights of these women. *See Carhart*, 11 F. Supp. 2d at 1121-22, 1127; *see also Hope Clinic*, 195 F.3d at 884 (Posner, C.J., dissenting) ("It is slight consolation to be told that while the state has forbidden the optimal treatment of your medical problem, that problem happily is rare."). Banning a procedure that may be the most appropriate even for a small fraction of women impermissibly endangers their health.[37]

III. THE ACT THREATENS WOMEN'S HEALTH BY HINDERING MEDICAL ADVANCEMENT.

The Act also endangers women's health by impeding physicians from developing new, and potentially safer, surgical techniques. This Court has long recognized that "present medical knowledge" changes, *see Akron*, 462 U.S. at 437, and that bans on abortion methods threaten to stymie medical advancement. Thus, in *Danforth*, the Court invalidated a broad ban on saline instillation because it threatened to preclude "methods that may be developed in the future and that may prove highly effective and completely safe." 428 U.S. at 78. The Act at

[37] Consider, for example, a ban on hysterotomies. Despite data indicating that hysterotomies are significantly more dangerous than every common method of abortion except hysterectomy, *see* Lawson at 1367 (Table II), a small number of abortions continue to be performed by hysterotomy each year because physicians resort to this procedure in specific and serious health situations. *See* CLINICIAN'S GUIDE at 126 (hysterotomy indicated for "life threatening medical crises such as unremitting hemorrhage associated with placenta accreta, massive disseminated intravascular coagulation (DIC), or severe forms of preeclampsia"); Koonin at 41 (Table 18) (36 reported abortions in 1996 were performed by hysterotomy or hysterectomy). It would be medically inappropriate to ban hysterotomy because, for a small number of women each year, that procedure was the safest in their particular health circumstances. A ban on D&X—even if D&X is the safest option for only a handful of women—is similarly medically inappropriate and unconstitutional.

issue here also fails to leave room for medical evolution and thus violates a guiding principle of this Court's prior abortion rulings.

The most common abortion procedures used today were all developed by physicians seeking safer procedures. For example, vacuum aspiration developed as a safer alternative to dilatation and curettage ("D&C"), which was slower, less thorough, and caused many more complications. *See* Pak at 54. Although vacuum methods for uterine evacuation were known as early as 1872, *see* CLINICIAN'S GUIDE at 107, it was only after abortion became legal nationwide in 1973 that physicians were free to develop the vacuum aspiration technique to the point where it has replaced D&C as the preferred method of first-trimester abortion.[38]

Likewise, D&E was developed in the early 1970s in response to the shortcomings of inductions (*see* Part B.2.b., *supra*) and the lack of an effective procedure between 12 and 16 weeks LMP, when inductions often cannot reliably be performed. For several years, physicians labored alone to develop a surgical procedure; finally, in 1975, D&E techniques began to be shared among physicians. D&E has become the most common and safest post-first-trimester abortion method in large part due to the ingenuity of physicians looking for better options for their patients. *See* GLICK at 46-48; *see also Akron*, 462 U.S. at 435-37. One of the reasons D&E safety has itself improved so markedly is that physicians have experimented with slightly varying techniques in performing it, and have taught the different techniques to colleagues. *See, e.g.*, GLICK at 47.

[38] *See* CLINICIAN'S GUIDE at 107-08; Jane E. Hodgson, *Abortion by Vacuum Aspirator*, *in* ABORTION AND STERILIZATION: MEDICAL AND SOCIAL ASPECTS 225, 225-26, 234-39 (Jane E. Hodgson ed., 1981); Pak at 54.

The variation of D&E techniques among physicians arises from innovation during surgical procedures, either in response to some unforeseen circumstance or as a result of an observation made by the physician in the course of the procedure. D&X thus arose as a minor variant of D&E. *See, e.g.*, CLINICIAN'S GUIDE at 136. As discussed above, D&X may offer a variety of safety advantages over D&E and induction methods. Permitted to evolve, D&X could well turn out to improve abortion safety markedly or lead to the discovery of one or more other techniques that would effect such improvement. Nebraska's "partial-birth abortion" ban and others like it, if permitted to stand, would ensure that this potential will never be realized.[39]

IV. THE ACT LACKS CONSTITUTIONALLY COMPELLED EXCEPTIONS TO PROTECT A WOMAN'S HEALTH AND TO SAVE HER LIFE.

The Act also is unconstitutional because it fails to exclude from its ban situations in which a woman's health or life is at risk. *Casey* made clear that any regulation of abortion must contain an exception "for pregnancies which endanger the woman's life or health." *Casey*, 505 U.S. at 846. In contravention of this command, the Act lacks any health exception whatsoever, and contains a constitutionally inadequate life exception.

As *Casey* recognized, pregnancy can often place a woman's life or health in jeopardy. In such circumstances, a physician must be permitted not only to provide an abortion, but also to use the method he or she determines to be most medically appropriate: In a medical emergency requiring quick response to rapidly changing circumstances, permitting a physician the discretion to

[39] There will be no opportunity for the safety and benefits of D&X to be recognized in peer-reviewed studies—the lack of which both the State and its *amici* use to condemn the technique (Pet. Br. 39; AAPS Br. 14-15)—if there is a criminal prohibition on its use.

use the full range of treatment options is particularly crucial. Given the Act's breadth, its omission of a health exception is clearly unconstitutional. Because D&X is the most medically appropriate abortion method in some situations, however, the lack of a health exception would condemn the Act even if it could be construed to target only D&X. The Act would force a woman whose health is threatened by pregnancy to choose between undergoing an abortion procedure more dangerous to her health than D&X and continuing her pregnancy in the face of potentially serious health risks. This *Casey* clearly forbids. 505 U.S. at 846, 879-80.

The State's suggestion that the absence of a health exception is constitutionally permissible because such an exception is not "necessary in all circumstances or even in a large fraction of circumstances" (Pet. Br. 31) misconstrues this Court's precedent. *Casey* held that the State can *never* interfere with "*a* woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." 505 U.S. at 880 (emphasis added). The requirement of a health exception continues throughout pregnancy and applies even after fetal viability when the state is otherwise free to ban abortion. *Id.* at 877-78. There is no need to show that the health of "a large fraction" of women needing an abortion (or specifically, a D&X) will be jeopardized by the Act. The "large fraction" test simply does not apply where a woman's health is at risk. If, as here, an abortion restriction will endanger the health of *any* woman, the restriction must contain a health exception.

The Act's narrow and wholly inadequate life exception also contravenes *Casey* and jeopardizes women's health. The Act permits a physician to perform a "partial-birth abortion" only if the banned procedure is "necessary to save the life of the mother." Neb. Rev. Stat. § 28-328(1). If a hysterotomy or hysterectomy would save a woman's

life, the Act requires the physician to resort to those procedures even though they present far greater risks to the woman's health and future fertility than any of the banned procedures. The Act's life exception is further deficient because it is limited to situations in which the woman's life is threatened by a "physical disorder, physical illness, or physical injury." *Id.* Such a limitation violates *Casey*'s command that abortion restrictions contain an exception for *any* threat to a woman's life. *See Casey*, 505 U.S. at 879. Finally, the Act does not clearly permit physicians to rely on their own best medical judgment in determining whether a banned procedure is necessary to save a woman's life. *See Colautti*, 439 U.S. at 395-96, 401. Even physicians who act in good faith in a medical emergency risk imprisonment and loss of license if their decisions are later second-guessed. The Act therefore hinders a physician's ability to provide his or her patients with the best medical care.

CONCLUSION

For the reasons set forth above, the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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Supreme Court of the United States

OCTOBER TERM, 1999

DON STENBERG, Attorney General of the State of Nebraska, *et al.*,

Petitioners,

—v.—

LEROY CARHART, M.D.,

Respondent.

ON WRIT OF *CERTIORARI* TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF OF *AMICI CURIAE* THE AMERICAN CIVIL LIBERTIES UNION; EMW WOMEN'S SURGICAL CENTER, P.S.C.; SAMUEL G. EUBANKS, M.D.; MARK I. EVANS, M.D.; MARILYNN CONNERS FREDERIKSEN, M.D.; NORMAN A. GINSBERG, M.D.; CASSING HAMMOND, M.D.; HERBERT HOLMES, M.D.; THE HOPE CLINIC; TIMOTHY R.B. JOHNSON, M.D.; ERNEST W. MARSHALL, M.D.; RHODE ISLAND MEDICAL SOCIETY; PABLO RODRIGUEZ, M.D.; DUANE ST. CLAIR, M.D.; LAUREN STREICHER, M.D.; GERSON WEISS, M.D.; GLENN H. WEYHRICH, M.D.; AND DAVID ZBARAZ, M.D., IN SUPPORT OF RESPONDENT

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INTERESTS OF *AMICI*[1]

Amici submit this brief in support of Respondents and in support of affirmance. *Amici* Drs. Samuel G. Eubanks, Mark I. Evans, Marilynn Conners Frederiksen, Norman A. Ginsberg, Cassing Hammond, Herbert Holmes, Timothy R.B. Johnson, Ernest W. Marshall, Pablo Rodriguez, Duane St. Clair, Lauren Streicher, Gerson Weiss, Glenn H. Weyhrich, David Zbaraz, EMW Women's Surgical Center, P.S.C., and The Hope Clinic are physicians and clinics that provide medical care, including abortions, to women in Idaho, Illinois, Kentucky, Michigan, New Jersey, and Rhode Island. *Amicus* Rhode Island Medical Society is a voluntary association of approximately 1500 physicians and medical students in Rhode Island -- some of whom provide abortions -- that advocates for quality medical care in Rhode Island. These *amici* are plaintiffs in cases that will be directly affected by the outcome in this case. The cases in which *amici* are parties are pending in this Court, in the United States Courts of Appeals for the First, Third, and Sixth Circuits, and in the United States District Courts for the District of Idaho[2] and the Eastern District of Michigan.

Amicus American Civil Liberties Union is a nationwide nonpartisan organization of nearly 300,000 members dedicated

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[1] Letters of consent to the filing of this brief have been lodged with the Clerk of the Court pursuant to Rule 37.3. Pursuant to Rule 37.6, counsel for *amici* state that no counsel for a party authored this brief in whole or in part, and no person, other than *amici*, their members, or their counsel, made a monetary contribution to the preparation or submission of this brief.

[2] *Amici* Drs. St. Clair and Weyhrich were plaintiffs in a challenge to Idaho's "partial-birth abortion" ban, in which the Idaho Attorney General consented to a permanent injunction. As an *amicus* before this Court, however, the Idaho Attorney General urges reversal of the decision below, suggesting that, should this Court reverse, the Idaho Attorney General may seek to vacate the injunction and enforce the Idaho ban.

to protecting the fundamental liberties and basic civil rights guaranteed by the United States Constitution. The ACLU has long been committed to protecting the constitutional right to reproductive choice, and has appeared in this Court in defense of that right in cases from *Doe v. Bolton*, 410 U.S. 179 (1973), to *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). The ACLU represents the other *amici* in the pending cases referenced above.

SUMMARY OF ARGUMENT

Under this Court's longstanding precedent, a law that prohibits the performance of safe and common abortion procedures cannot stand. *Planned Parenthood v. Danforth*, 428 U.S. 52, 75-79 (1976). Yet, as the Eighth Circuit and the district court in this case properly held, the Nebraska "partial-birth abortion" ban, Neb. Rev. Stat. §§ 28-326(9), 28-328(1)-(4) (1998) (the Act), at a minimum, reaches the dilation and evacuation (D&E) procedure, by which the overwhelming majority of second-trimester abortions in Nebraska and the nation are performed. That holding has been echoed by courts across the country invalidating similar or identical bans.

In the face of these holdings, the state insists that the Act proscribes only a variant of D&E known as dilation and extraction (D&X). Presumably recognizing that the language of the Act encompasses considerably more than D&X, the state offers revisions for this Court's consideration. Yet even if the Act were readily susceptible to the proposed constructions (which it is not), a ban rewritten to the state's specifications would still impermissibly prohibit D&E. A statute that criminalizes the most common method of second-trimester abortion unquestionably imposes an unconstitutional, undue burden on the right to reproductive choice.

Beyond assuring access to the most common abortion procedures, however, the Constitution protects a woman's right

to end her pregnancy by the method that is best for her health. A ban on any abortion procedure within the standard of care, including a ban on D&X alone, would deprive some women in some circumstances of access to the procedure safest for them, forcing them to submit instead to riskier methods. The district court's findings of fact in this case, amply supported by the evidence, establish that a ban on D&X would expose women to appreciably greater health risks -- including, among others, risks of cervical laceration, severe infection, and uterine perforation followed by massive hemorrhage -- than they would otherwise face. Even for women whose health conditions give them especially strong reasons to avoid these and other risks, the ban is absolute: It contains no exception to protect a woman's health and only an insufficient exception to save her life.

The Constitution does not permit the government to subordinate a woman's interest in protecting her health, even to the state's interest in preserving *viable* fetal life. *Casey*, 505 U.S. at 846, 879; *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 768-71 (1986), *overruled in part on other grounds by Casey*, 505 U.S. at 882; *Colautti v. Franklin*, 439 U.S. 379, 397-401 (1979). *A fortiori* the Constitution cannot tolerate a statute, like Nebraska's, that subjects women to riskier abortion procedures before viability when the fetus has no present chance of survival. Moreover, the Constitution mandates an exception to permit otherwise banned procedures when a pregnant woman's life or health is at stake. *Casey*, 505 U.S. at 846, 879-80. Because the Act prevents a woman from pursuing her overriding interest in preserving her health, it cannot survive the exacting scrutiny demanded by this Court's abortion jurisprudence.

Indeed, here, the state lacks even a legitimate interest in the ban it is defending. The Act advances neither of the two interests identified in *Casey* -- in protecting maternal health or fetal life. 505 U.S. at 871. The Act threatens, rather than

protects, the health of pregnant women. And if the Act is intended to ban only one procedure (as the state insists), it is plainly *not* meant to protect potential life, but rather to steer women from one abortion method to another. Nor is there evidence in any case filed anywhere in the nation establishing that the D&X procedure is more painful or cruel to the fetus than its alternatives or even that previable fetuses consciously experience pain. The remaining interests asserted by the state amount to expressions of repugnance, a limitless state interest that cannot be deemed legitimate. If repugnance alone were sufficient to support bans on various abortion procedures, a woman's right to obtain a safe and legal abortion would soon disappear. Yet this Court has held that the state may not "resolve the[] philosophic questions [surrounding abortion] in such a definitive way that a woman lacks all choice in the matter." *Casey*, 505 U.S. at 850.

ARGUMENT

I. THE ACT IMPERMISSIBLY PROHIBITS SAFE AND COMMON ABORTION PROCEDURES.

Along with the vast majority of courts to consider "partial-birth abortion" bans, the Eighth Circuit and the district court in this case properly held that such bans impose an undue burden on the right to reproductive choice because they reach safe and common procedures, and particularly D&Es. These holdings are based on amply supported findings that these common abortion methods contain all the elements of the conduct criminalized under the bans. Implicitly acknowledging that the words of the legislation cover too much, the state proffers interpretive glosses. Yet even if the new language urged by the state could be read into the ban, it would still criminalize D&E in general -- and not only the D&X variant of D&E.

A ban that reaches safe and common abortion procedures impermissibly "plac[es] a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." *Casey*, 505 U.S. at 878. In *Danforth*, for example, this Court held unconstitutional a ban on saline inductions, which then accounted for the vast majority of second-trimester abortions. 428 U.S. at 75-79. Relying in part on *Danforth*, this Court later struck down a requirement that all second-trimester abortions take place in a hospital. *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 431-39 (1983), *overruled in part on other grounds by Casey*, 505 U.S. at 882-85. Recognizing that D&Es -- which had begun to supplant saline inductions -- could be safely performed outside hospitals, this Court held that the ban on "the performance of D&E abortions in an appropriate nonhospital setting . . . imposed a heavy burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." *Id.* at 438.

Based on this and other precedent, courts across the country have invalidated "partial-birth abortion" bans because they prohibit previability procedures including D&E, by which over 90% of second-trimester abortions in this country are now performed. J.A. at 533 (Centers for Disease Control data).[3] In

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[3] *See Planned Parenthood v. Miller*, 195 F.3d 386, 388-89 (8th Cir. 1999), *aff'g* 30 F. Supp. 2d 1157, 1165-67 (S.D. Iowa 1998); *Carhart v. Stenberg*, 192 F.3d 1142, 1149-51 (8th Cir. 1999), *aff'g* 11 F. Supp. 2d 1099, 1127-31 (D. Neb. 1998); *Little Rock Family Planning Servs. v. Jegley*, 192 F.3d 794, 797-98 (8th Cir. 1999), *aff'g* No. LR-C-97-581, slip op. at 46-51 (E.D. Ark. Nov. 13, 1998); *Weyhrich v. Lance*, Civ. No. 98-0117-S-BLW, slip op. at 6-9, 10 (D. Idaho Oct. 12, 1999); *Rhode Island Med. Soc'y v. Whitehouse*, 66 F. Supp. 2d 288, 309-10, 313-14 (D.R.I. 1999), *appeal stayed*, No. 99-2095 (1st Cir. Nov. 22, 1999); *Causeway Med. Suite v. Foster*, 43 F. Supp. 2d 604, 614 (E.D. La. 1999), *appeal argued*, No. 99-30324 (5th Cir. March 2, 2000); *Planned Parenthoood v. Verniero*, 41 F. Supp. 2d 478, 493, 499-500 (D.N.J. 1998), *appeal argued*, No. 99-5042 (3d Cir. Nov. 19, 1999); *A Choice for* (continued...)

a D&E, as described by the district court below in findings properly affirmed by the Eighth Circuit, the physician first gradually dilates the cervix, over the course of hours or even days. At the start of surgery, the physician ruptures the membranes that enclose the amniotic sac. Inserting forceps through the cervix and into the uterus, the physician then grasps "a portion of the fetus, pulls it through the cervical os [the dilated but still narrow opening of the cervix], and dismembers various fetal parts by traction created between the instrument and the cervical os." *Carhart*, 11 F. Supp. 2d at 1104; 192 F.3d at 1147, 1150. Thus, the dismemberment of the fetus typically occurs "after a part of the fetus has been pulled through the cervix, into the vagina." *Carhart*, 192 F.3d at 1147. The physician completes the removal of the fetus after causing its death by repeatedly grasping fetal parts, delivering them into the vagina, and dismembering them at the cervical os. *See Carhart*, 11 F. Supp. 2d at 1103-05; 192 F.3d at 1146-48.

In "an effort to minimize perforation of the uterus or cervix by instruments used during a D&E or from piercing caused by fetal parts," some physicians attempt to deliver the fetus in as intact a condition as possible. *Carhart*, 11 F. Supp. 2d at 1105. In one form of intact delivery during a D&E, the physician "brings all of the fetus, except for the head, out of the uterus into the vagina. Because the cervix is not dilated enough to allow the head to pass through, the physician . . . collaps[es] the skull[,] allowing removal of an [otherwise] intact fetus." *Carhart*, 192 F.3d at 1147-48. A D&E that proceeds in this way is here referred to as a D&X.

The state insists that its "partial-birth abortion" ban proscribes only the D&X procedure. Whatever meaning the state may ascribe to the non-medical term "partial-birth abortion," *see* Pet'rs' Br. at 7, 15, "[t]he issue here is *the Act's* definition," *Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 305 (emphasis added), which is binding. As this Court has made clear, a statutory "definition which declares what a term 'means' . . . excludes any meaning that is not stated." *Colautti*, 439 U.S. at 392 n.10 (internal quotation omitted).

The Act bans any abortion in which the physician

> partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. . . . [T]he term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the [physician] knows will kill the unborn child and does kill the unborn child.

Neb. Rev. Stat. § 28-326(9). Several courts have correctly held that virtually identical language -- and particularly the imprecise phrase "substantial portion" -- impermissibly leaves physicians uncertain about what abortion procedures the statute prohibits

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[3](...continued)
Women v. Butterworth, 54 F. Supp. 2d 1148, 1155-56 (S.D. Fla. 1998); *Eubanks v. Stengel*, 28 F. Supp. 2d 1024, 1034-35 (W.D. Ky. 1998), *appeal argued*, No. 99-6671 (6th Cir. Dec. 15, 1999); *Intermountain Planned Parenthood v. Montana*, No. BDV 97-477, slip op. at 4, 12-13 (Mont. Dist. Ct. June 29, 1998); *Planned Parenthood v. Alaska*, No. 3AN-97-6019 CIV, slip op. at 9-10, 15-17 (Alaska Super. Ct. Mar. 13, 1998), *appeal docketed*, No. S-08610 (Alaska Apr. 13, 1998); *Planned Parenthood v. Woods*, 982 F. Supp. 1369, 1377-78 (D. Ariz. 1997); *Evans v. Kelley*, 977 F. Supp. 1283, 1317-18 (E.D. Mich. 1997); *cf. Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 198-201 (6th Cir. 1997) (definition of banned procedure in D&X ban encompassed D&Es), *aff'g* 911 F. Supp. 1051, 1063-67 (S.D. Ohio 1995).

and is therefore unconstitutionally vague.[4] *Amici* agree. Whatever the precise scope of the bans, however, one thing is clear: The banned conduct includes D&Es.

This is evident from the elements of the crime of "partial-birth abortion." The state itself recognizes that the Act proscribes any procedure "involving the intentional '1) partial delivery of a living fetus vaginally, 2) killing the fetus and 3) completing the delivery.'" *Carhart*, 192 F.3d at 1150 (quoting 8th Cir. Br. of Nebraska at 66-67). As the Eighth Circuit correctly held, "the D&E procedure involves all three of those steps. The physician intentionally brings a substantial part of the fetus into the vagina, dismembers the fetus, leading to fetal demise, and completes the delivery." *Id.* As another court found, considering a ban nearly identical to Nebraska's,

> In a D&E abortion, ... part of the intact fetus may be in the vagina and part in the uterus or a disarticulated part of the fetus may be in the vagina while the remainder of the fetus is in the uterus. The fetus may still have a heartbeat. . . . In any of these situations, the next step taken by the physician, before completing the delivery, may kill the fetus. This would bring the D&E within the Act's definition of a "partial-birth abortion."

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[4] *E.g., Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 309, 310-12 ("'substantial portion' is vague and does not provide doctors with sufficient guidance to know what the Legislature has made illegal"); *Butterworth*, 54 F. Supp. 2d at 1157-58 (same as to "partially vaginally delivers"); *Miller*, 30 F. Supp. 2d at 1165 (same as to "partially vaginally delivers," "substantial portion," and "living fetus"); *Verniero*, 41 F. Supp. 2d at 491-94 (same as to "partially vaginally delivers," "living human fetus," and "substantial portion"); *Evans*, 977 F. Supp. at 1305-11 (same as to "partially vaginally delivers a living fetus").

Verniero, 41 F. Supp. 2d at 493. Accordingly, the district court in this case held that "[t]he words of the statute, fairly read, prohibit the D&E procedure" because "[d]octors routinely 'deliberately and intentionally' deliver 'vaginally' a 'substantial portion' of a living fetus in order to kill it when performing a D&E." *Carhart*, 11 F. Supp. 2d at 1128, 1129. This holding is echoed by courts striking similar or identical "partial-birth abortion" bans throughout the country.[5]

None of the judicial tampering with the legislation that the state -- or state defendants in other cases -- have urged would exclude D&E from the Act's prohibition. Even if the ban were rewritten to limit its application to partial deliveries of *intact* fetuses -- a revision numerous courts have declined to make,[6] and one the state urges only by implication -- such an interpretation would not exclude D&E. For, as discussed above, "when a fetus is dismembered [in a D&E] the dismemberment routinely involves an intentional and deliberate vaginal delivery of a 'substantial portion' of the *intact* fetus in order to

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[5] *See supra* note 3. Based on similar factual findings, several of these courts have also held that the bans would prohibit some first-trimester suction curettage abortions, in which the physician evacuates the uterus by means of suction, and some second-trimester induction abortions, in which the physician induces premature labor. *Miller*, 195 F.3d at 389 (suction curettage); *Jegley*, 192 F.3d at 798 (suction curettage); *Butterworth*, 54 F. Supp. 2d at 1155-56 (induction); *Verniero*, 41 F. Supp. 2d at 493 (suction curettage and induction); *Weyhrich*, Civ. No. 98-0117-S-BLW, slip op. at 6, 10 (suction curettage and induction); *Woods*, 982 F. Supp. at 1378 (induction); *cf. Causeway*, 43 F. Supp. 2d at 614; *Planned Parenthood v. Alaska*, No. 3AN-97-6019 CIV, slip op. at 17.

[6] *E.g.*, *Verniero*, 41 F. Supp. 2d at 491-94; *Miller*, 30 F. Supp. 2d at 1165-66; *Evans*, 977 F. Supp. at 1306-07.

accomplish dismemberment." *Carhart*, 11 F. Supp. 2d at 1121 (emphasis added); *see also Carhart*, 192 F.3d at 1147, 1150.[7]

Reading "intact" into the Act would not remove D&E from its sweep for the additional reason that dismemberment is not a necessary part of all D&Es. Contrary to the state's assertion, the "object" of a D&E is not "to dismember" the fetus, Pet'rs' Br. at 7, but rather, as in all abortions, to empty the uterus as safely as possible for the woman. *Verniero*, 41 F. Supp. 2d at 494. "For reasons of medical safety," physicians attempt to minimize repeated instrumentation inside the uterus by "bring[ing] as much of the fetus into the vagina as possible when performing a D&E." *Eubanks*, 28 F. Supp. 2d at 1035. Dr. Carhart, for example, "intends to remove the fetus intact for any abortion performed past 15 weeks' gestation," although he achieves intact delivery in only a small percentage of cases. *Carhart*, 11 F. Supp. 2d at 1106, 1108, 1121-22. A physician, like Dr. Carhart, who aims to increase the safety of D&E by delivering as much of the fetus as possible with each pass of the instrument, knows that the procedure may progress in a way that brings it within the scope of prohibited conduct, even as narrowly drawn as the state claims: The physician may deliver an intact fetus in breech position up to the head and then

[7] The state also fails to narrow the Act through its claim that "a distinguishing feature of the statute is its focus on the place where the killing act occurs." Pet'rs' Br. at 17. This argument hinges on the state's mistaken belief that the "killing act" of a D&X occurs in the vagina, whereas in a D&E the act that causes fetal demise occurs in utero. That characterization is both overly simplistic and wrong. As just described, when a D&E entails dismemberment, that "killing act" generally occurs when the physician's instruments are grasping a fetal part *outside* the uterus that is still attached to the rest of the fetus, which remains in utero. *See, e.g.*, *Carhart*, 192 F.3d at 1147. Conversely, in a D&X, "the puncture and suctioning [of the skull] occurs *inside* the uterus." *Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 307 (emphasis added).

collapse the skull if it lodges within the uterus. *E.g.*, *Verniero*, 41 F. Supp. 2d at 484, 493.

In addition to illustrating the breadth of the Act, these facts reflect what the state goes to great lengths to obscure by rhetorically contrasting "D&X" with "the D&E dismemberment procedure," Pet'rs' Br. at 7, 11, 15-17: D&X is "a form of D&E" or "a variant" of it, *Carhart*, 11 F. Supp. 2d at 1105, 1121 (internal quotations and citations omitted). The two procedures are not as easily distinguished as the state would have the Court believe, and nothing in the Act targets one while excluding the other. *See Hope Clinic v. Ryan*, 195 F.3d 857, 879 (7th Cir. 1999) (en banc) (5-4 decision) (Posner, C.J., dissenting) ("[I]t is extremely difficult, indeed probably impossible, to distinguish a 'partial birth' abortion from the methods of abortion that are conceded to be privileged."); *Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 297-98 ("D&X is merely a subset, a defined group of procedures that would have been called a D&E until doctors and medical groups carved it out.").

As is apparent from this discussion of how D&Es are actually performed, even if the Court were to accept Nebraska's latest and more elaborate articulation of the elements of the crime -- with its reference to partial delivery for the purpose of performing a "separate and distinct 'procedure'" that kills the fetus, Pet'rs' Br. at 17; *see also id.* at 14 -- the Act would still ban D&E in general, and not only D&X.[8] In a D&E involving

[8] Inserting words absent from the Act -- such as "separate and distinct" before the word "procedure," Pet'rs' Br. at 17 -- would be improper for several reasons. First, if, as here, a statute is not "'readily susceptible'" to a limiting construction, federal courts "will not rewrite a state law to conform it to constitutional requirements." *Virginia v. American Booksellers Ass'n*, 484 U.S. 383, 397 (1988); *see also Reno v. ACLU*, 521 U.S. 844, 884 (1997). Second, as described in the text accompanying this note, inserting these words would not in any event prevent application of the Act to D&E, which

(continued...)

dismemberment, "[t]he doctor grabs a substantial portion of the fetus and delivers it into the vagina. This is done with the intent of performing a second procedure -- the pulling and traction -- that the doctor knows will kill" the fetus. *Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 309; *see also Carhart*, 192 F.3d at 1150 ("The physician intentionally brings a substantial part of the fetus into the vagina, dismembers the fetus, leading to fetal demise, and completes delivery."); *Eubanks*, 28 F. Supp. 2d at 1035 (in a D&E, physicians "deliver a leg or arm or more of the fetus intact into the vagina. . . . 'before' then performing a

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[8](...continued)
the state concedes to be constitutionally protected. *See Houston v. Hill*, 482 U.S. 451, 468-69 & n.18 (1987) (refusing to certify question of statutory construction where, "even if there were" a "reasonable way to read the plain language" of the law as the state urged, "such a limitation would not significantly limit its scope"). Finally, to the extent that the state insists on the relevance of the legislative history of the *federal* ban, *see* Pet'rs' Br. at 3-4, 43-44, that history indicates that, when originally added to the federal bill, the term "procedure" in the "for the purpose" clause referred to the abortion itself, and not to a "separate and distinct" sub-procedure within the abortion. The clause was meant to distinguish abortions from intended live deliveries that had gone awry. Introducing the 1997 federal amendment that added the phrase, "for the purpose of performing a procedure the physician knows will kill the fetus," H.R. 1122, 105th Cong. (1997), the Senate sponsor explained:

> [T]he AMA was concerned that . . . some zealous prosecutor could come out and accuse the doctor, who has not performed an abortion -- *does not intend to perform an abortion* -- but performed a normal delivery and, because of a complication, that somehow he or she could be covered under this act. We have tightened up the language with mens rea, to use the legal term. That directs the mental state -- *as to what the doctor was doing when he was delivering the baby for the purpose of a live birth and is not doing an abortion.*

143 Cong. Rec. S4671 (daily ed. May 19, 1997) (Sen. Santorum) (emphases added).

procedure or procedures which they know will kill the fetus" (citation omitted)).[9]

For all of these reasons, the Eighth Circuit correctly found that D&Es contain all the elements of conduct proscribed under the Act. Based on that finding, this Court should affirm the Eighth Circuit's holding that the Act "'plac[es] a substantial obstacle in the path of a woman seeking a pre-viability abortion' . . . and, in doing so, imposes an undue burden." *Carhart*, 192 F.3d at 1151 (citations omitted).

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[9] Were the Court to accept the state's insupportable assertion that the Act targets only abortions in which the physician performs "a separate and distinct 'procedure' *used to* kill" the fetus, Pet'rs' Br. at 17 (emphasis added), the Act would reach no abortions whatsoever, including D&X. For the record is clear that physicians performing D&X abortions collapse the skull only because it will not otherwise fit through the cervix; that they collapse the skull for the sole purpose of removing it; and that they proceed the same way regardless of whether the fetus has already died. *Carhart*, 192 F.3d at 1147-48 & n.9, *aff'g* 11 F. Supp. 2d at 1105-07, 1111. The purpose of either collapsing the fetal skull or dismembering the fetus is to complete the evacuation and not, specifically, to ensure fetal demise.

The state similarly fails to distinguish D&X as a targeted procedure when it asserts that D&X involves no "uncertainty as to when death will occur." Pet'rs' Br. at 18. The Act specifies a "procedure" that the physician knows will kill the fetus, and that does kill the fetus, before completion of the delivery; no more precise time of fetal demise is set forth. The physician knows that either dismemberment or collapsing the fetal skull will generally kill the fetus before the delivery is complete.

II. A BAN ON ANY ABORTION PROCEDURE WITHIN THE STANDARD OF CARE IMPERMISSIBLY HARMS WOMEN'S HEALTH, AND THE RISKS ARE ESPECIALLY GRAVE WHEN THE BAN INCLUDES NO HEALTH EXCEPTION AND ONLY AN INADEQUATE LIFE EXCEPTION.

Whenever the state criminalizes an abortion procedure that is within the standard of care, the ban removes from the physician's array of options a method that is the safest for some women in some circumstances. The ban compromises these women's health by forcing them from safer to riskier abortion procedures and depriving them of the right to decide from among medically approved alternatives which method best meets the compelling personal needs that surround their abortion decisions. Thus, even if the Act were somehow construed to prohibit only the D&X procedure, that prohibition would still unconstitutionally deny some women access to the method most protective of their health. The threatened harm is especially acute where, as here, the ban contains no exception to preserve a woman's health and only an inadequate exception to save her life. Because Nebraska's and the other states' "partial-birth abortion" bans, however construed, pose gratuitous risks to women's health, they are unconstitutional.

From *Roe v. Wade*, 410 U.S. 113 (1973), to *Planned Parenthood v. Casey*, 505 U.S. 833, this Court has held that the Constitution does not tolerate abortion restrictions that endanger women's health. Statutes that either prohibit or prescribe certain abortion methods have met with particular skepticism because of the health risks that flow from legislative attempts to micro-manage surgical technique. *See Danforth*, 428 U.S. at 75-79; *Colautti*, 439 U.S. at 397-401; *Thornburgh*, 476 U.S. at 768-69.

In *Danforth*, this Court identified several constitutional problems with a law banning saline induction. The statute prohibited what was then the most common method of post-first-trimester abortion. 428 U.S. at 77. The ban appeared also to encompass other existing abortion techniques as well as "methods that may be developed in the future and that may prove highly effective and completely safe." *Id.* at 78. And the law was anomalous in failing to prohibit "techniques that are many times more likely to result in maternal death." *Id.*

This reasoning goes beyond establishing a constitutional restraint on the prohibition of a common abortion procedure. The Court's stated concerns about laws that stymie medical progress and steer women to less safe alternatives apply even to a ban that takes narrow aim at a relatively new and still comparatively uncommon method, as the state argues is the case here. Thus, even if the Act prohibited only D&X (which it does not), and even if D&X could be consistently and reliably distinguished from D&E (which it cannot), the ban would still prevent the medical profession from fully assessing the safety advantages of D&X and perfecting the technique to maximize those advantages. Yet medical advancement in general and the ever-increasing safety of abortion practice in particular depend upon this process of developing, evaluating, and perfecting new techniques.[10] Similarly, even a ban that targeted only the D&X

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[10] In an attempt to establish -- in the face of amply supported, contrary findings by the district court, *Carhart*, 11 F. Supp. 2d at 1123-27 -- that the D&X procedure lacks medical benefits, the state emphasizes that D&X is a "relatively little used procedure," which has not yet been the subject of medical studies. Pet'rs' Br. at 32, 39. This, of course, will be true at some point for every new advance in surgical technique. The relative rarity of D&X and the paucity of studies establishing its safety are particularly unsurprising, given not only that it was only recently identified as a modification of D&E, but also that a sustained attack followed that identification. *See, e.g., Carhart*, 11 F. Supp. 2d at 1124-25 (finding that (continued...)

would "force[] a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." *Danforth*, 428 U.S. at 79; *see* discussion *infra* pages 19-21.

If *Danforth* left any doubt about the unconstitutionality of a law that forces a woman to undergo what for her would be a riskier procedure, *Colautti* and *Thornburgh* resolve the question. In *Colautti*, this Court held void for vagueness a statute that directed a physician, performing an abortion when the fetus was viable or potentially viable, to use the technique most likely to preserve its life, unless a different technique was "'necessary in order to preserve the life or health of the mother.'" 439 U.S. at 397 (quoting statute). Interpreting the word "necessary" in this context to suggest that a procedure be "indispensable to the woman's life or health -- not merely desirable," *id.* at 400, the Court concluded,

> [I]t is uncertain whether the statute permits the physician to consider his duty to the patient to be paramount to his duty to the fetus, or whether it requires the physician to make a "trade-off" between the woman's health and additional percentage points of fetal survival. . . . [W]here conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision . . . .

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[10](...continued)
"many accepted surgical techniques . . . are commonly developed without statistical studies" and that D&X is "well within accepted medical practice"); *Voinovich*, 911 F. Supp. at 1068-69 (rejecting argument that absence of studies requires conclusion that D&X has no benefits, and noting that "given the security concerns which must be considered by doctors who perform abortions, physicians who use the D&X procedure may be understandably reluctant to publicly acknowledge that they use this procedure, and may be even more reluctant to participate in a study and publish the results").

Id. at 400-01.

Faced with a similar statute several years later in *Thornburgh*, the Court declined to address the vagueness issue and invalidated the law instead on the ground that it violated a woman's right to end her pregnancy by the means safest for her. 476 U.S. at 768-69 & n.14. The statute at issue required the physician to employ the procedure most likely to ensure that a viable fetus would be "'aborted alive unless,' in the physician's good-faith judgment, that technique 'would present a significantly greater medical risk to the life or health of the pregnant woman.'" *Id.* at 768 (quoting statute). Because the statute "require[d] the mother to bear an increased medical risk in order to save her viable fetus," the Court condemned the provision for preventing the physician from treating "maternal health" as his or her "paramount consideration." *Id.* at 768-69 (internal quotations omitted).

In *Casey*, the Court reaffirmed that a pregnant woman's overriding interest in protecting her health lies at the core of her constitutionally protected right to reproductive choice. Thus, the *Casey* decision continues to prevent states from restricting abortions even after fetal viability -- when the state's interest in protecting potential life is at its zenith -- unless the law provides exceptions for abortions that are necessary to preserve a woman's life or *health*. 505 U.S. at 846, 879. The Court upheld the medical emergency exception of the statute under review only after adopting a construction that "assure[d] that compliance with [the state's] abortion regulations would not *in any way* pose a significant threat to the life or health of a woman." *Id.* at 880 (internal quotations omitted) (emphasis added). Similarly, the Court upheld the statute's waiting period only after concluding, on the record before it, that "we cannot say that the waiting period imposes a real health risk." *Id.* at

886.[11] Had the statute subjected women to real health risks, the plurality opined, "we would be required to invalidate the restrictive operation of the provision." *Id.* at 880. Thus, under *Casey*, an abortion regulation that exposes women to real health risks by definition poses a substantial obstacle and imposes an undue burden. *Id.*

Where, as here, the state lacks even a legitimate interest in restricting the procedures a physician may use to terminate a pregnancy, *see infra* Point III, *any* incremental risk to the woman's health is unjustified. Under *Colautti* and *Thornburgh*, the state may not compel a woman to undergo a riskier abortion procedure even to save the life of a viable fetus. *A fortiori*, then, the state may not in this case relegate a woman to riskier procedures for *previability* abortions, when the fetus cannot survive outside the woman's body regardless of the method used to terminate the pregnancy. The ban at issue here poses real risks to more women (because more women seek abortions before fetal viability than after), and the state interests asserted are far weaker.

Indeed, by insisting that the ban prohibits only one, discrete, rare abortion procedure and leaves adequate alternatives available, the state in effect disclaims any interest in preserving the life of the fetus. This Court has never suggested that the state has any cognizable interest in regulating the means by which a physician causes the death of the fetus in an abortion, aside from regulations designed to promote maternal health (which this ban certainly is not). Nor is there a scintilla of evidence, in this case or any other, that the method the state

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[11] *See also Webster v. Reproductive Health Servs.*, 492 U.S. 490, 525 (1989) (O'Connor, J., concurring) (interpreting viability-testing requirements to mandate "only those tests that are useful . . . [and] that it would not be imprudent or careless to perform in the particular medical situation before the physician" (internal quotations omitted)).

claims to target is more cruel to the fetus than its alternatives or that a previable fetus experiences pain. *See infra* Point III. Because the Act in no way serves the state's interest in protecting fetal life, or any other legitimate interest, *id.*, the health risks it imposes are entirely gratuitous. In the absence of a state interest in potential life, nothing distinguishes this ban from a regulation that arbitrarily prohibits radiation as opposed to chemotherapy for cancer patients, or open heart surgery as opposed to angioplasty for patients at risk of heart failure. Yet a decision from among such treatment options, with full knowledge of their risks and benefits, has long been the patient's to make. As this Court recognized in *Casey*, "*Roe* . . . [has] doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection." 505 U.S. at 857 (citing, *inter alia*, *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (1990)).

In this case, the unwarranted risks to the health of pregnant women are real indeed. A statute that criminalizes D&E, and potentially also induction and suction curettage, *see supra* Point I, inevitably consigns women to narrow and dangerous alternatives. Even if the ban prohibited only D&X, however, the record in this and other cases establishes that, in the hands of a trained and experienced provider, that procedure may be even safer than D&E for some women. The district court's findings, based on extensive testimony and documentary evidence, list in detail several medical advantages of D&X:

> Intact removal of the fetus lowers maternal complications by preventing sharp fragments, such as pieces of long bone or skull fragments, from passing through the cervical os without some kind of covering or protection. . . .
>
> [I]ntact removal of the fetus minimizes the risk of damage to maternal structures from repeated

> use of instrumentation in the uterine cavity. The more times [the physician] must enter the uterus with an instrument, the more the complication rate multiplies. . . .
>
> Performing the . . . D&X procedure also allows a more accurate assessment of whether the uterine cavity has been emptied. Fetal and placental debris remaining in the uterus -- as is possible with a D&E involving dismemberment -- can cause infection, greater bleeding, and [other] risk[s].

11 F. Supp. 2d at 1107. Courts throughout the country have made similar findings based on similar evidence.[12] A ban on D&X would therefore subject abortion patients to "appreciably greater risks to their health and lives than are necessary." *Id.* at 1127.

Because D&X reduces the risks of cervical laceration, uterine perforation, and infection, among others, it has both advantages in general and particular benefits for some women. Several courts have found, for example, that D&X may be indicated when a fetus has a greatly enlarged head resulting from hydrocephaly or when an intact fetus would facilitate genetic testing for the complete assessment of fetal anomalies and of the

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[12] *See, e.g.*, *Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 314 (D&X may be best procedure to save life or preserve health of woman); *Miller*, 30 F. Supp. 2d at 1161 (D&X is used to "minimize uterine or cervical perforation caused by fetal parts or by medical instruments"); *Jegley*, No. LR-C-97-581, slip op. at 55-56 (D&X "may be necessary in some situations to preserve the health of the woman" because it poses less risk of laceration and hemorrhaging than D&E); *Butterworth*, 54 F. Supp. 2d at 1153 (D&X reduces risk of uterine or cervical perforation); *Evans*, 977 F. Supp. at 1296 (detailing unanimous testimony of six expert physicians that D&X reduces risks associated with D&E, including risk of uterine perforation, cervical lacerations, hemorrhaging, and infection); *Voinovich*, 911 F. Supp. at 1069-70 (same).

risk of their recurrence in future pregnancies.[13] Similarly, because D&X involves relatively little instrumentation within the uterus, it may be the best procedure for women whose uteruses are particularly fragile because of scarring from prior surgery. *Voinovich,* 911 F. Supp. at 1067. Then, too, some women decide to have a D&X because they want an intact fetus so that they can hold it, grieve its loss, and bury it. *See* J.A. at 67-68 (testimony of Dr. Carhart); *see also* Maureen Paul, M.D., M.P.H., *et al.*, *A Clinician's Guide to Medical and Surgical Abortion* 136 (1999). For reasons like these, the American College of Obstetricians & Gynecologists has concluded that, although D&X (like any single procedure) may virtually never be "the *only* option to save the life or preserve the health of the woman," it may nevertheless be "the *best or most appropriate* procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based on the woman's particular circumstances can make this decision." J.A. at 600-01 (ACOG Statement of Policy) (emphases added).

Finally, the Act prohibits medically accepted procedures without any exception to protect a woman's health and with only an inadequate exception to save her life. Thus, a banned procedure is unavailable to *all* women in virtually all circumstances, *even when* medically indicated. This deficiency alone is fatal to the Act. An adequate medical emergency exception is the *sine qua non* of the constitutionality of a law restricting abortion because "the essential holding of *Roe* forbids a State from interfering with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." *Casey*, 505 U.S. at 879-80.

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[13] *See, e.g.*, *Butterworth*, 54 F. Supp. 2d at 1153; *Verniero*, 41 F. Supp. 2d at 485; *Jegley*, No. LR-C-97-581, slip op. at 55-56; *Evans*, 977 F. Supp. at 1296; *Voinovich*, 911 F. Supp. at 1067.

When pregnancy threatens a woman's life or health, physicians must be permitted not only to provide an abortion, but also to use the method that they determine, in their best medical judgment, to be the safest for the patient. *See, e.g.*, *Thornburgh*, 476 U.S. at 769; *Colautti*, 439 U.S. at 387 ("*Roe* stressed repeatedly the central role of the physician, both in consulting with the woman about whether or not to have an abortion, *and in determining how any abortion was to be carried out*." (emphasis added)). In medical emergencies, the need for discretion is particularly acute, as the physician must rapidly and effectively make the best use of his or her experience to deal with a highly particularized, rapidly changing situation with potentially devastating consequences. *See, e.g., Voinovich*, 130 F.3d at 205 (denying physicians discretion to exercise good faith judgment could impermissibly chill them from performing abortions even "when the woman's health or life is threatened"); *Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 314 ("During an emergency, doctors must act rapidly and address ever-changing crises. The state may not risk a woman's life merely because the tool for saving her life would be a particular abortion technique.").

In the face of these constitutional requirements and medical realities, the Act is fatally inadequate. Because it lacks a health exception, the Act forces a high-risk patient to make an untenable decision between undergoing a more dangerous procedure or continuing her pregnancy notwithstanding unknown health risks. *See, e.g.*, *Verniero*, 41 F. Supp. 2d at 502. Because a physician cannot always clearly distinguish between a threat to a pregnant woman's health and a threat to her life, those health risks may reach grave proportions. *See, e.g.*, *id.* (striking ban that would "[f]orc[e] a physician to wait until a pregnancy threatens a woman's life before resorting to a 'partial-birth abortion'"). Courts across the country have therefore

invalidated so-called "partial-birth abortion" bans for lack of constitutionally mandated health exceptions.[14]

Even the Act's life exception is inadequate. It exempts a physician from liability only if a banned procedure "*is necessary to save the life* of the mother whose life is endangered by a physical disorder, physical illness, or physical injury." Neb. Rev. Stat. § 28-328(1) (emphasis added). Thus, for example, if a hysterectomy or hysterotomy would also save a woman's life, the ban requires the physician to use that method even though it presents far greater risks to the woman's health. *See, e.g.*, *Verniero*, 41 F. Supp. 2d at 500 ("[P]hysicians who wish to continue performing abortions without risking exposure . . . may still perform hysterectomies and hysterotomies. However, these procedures carry enhanced risks of morbidity and mortality and hysterectomies render the woman sterile."); *Evans*, 977 F. Supp. at 1317-18 (same). Moreover, by limiting the exception to life-threatening physical conditions -- as opposed to mental illnesses that often cannot be optimally treated during pregnancy and that may render the woman so dangerous to herself as to threaten her life -- the Act violates *Casey*'s command that abortion restrictions contain an exception to save a woman's life, whatever the source of the risk. *See* 505 U.S. at 879. Furthermore, the Act does not clearly allow physicians to rely on their own best medical judgment in determining that a banned procedure is necessary to save the patient. Yet physicians can and do regularly differ, both about the point at which a patient's condition becomes life-threatening and about the steps that may be necessary to keep her alive. *See, e.g.*, *Voinovich*, 130 F.3d at 205. A provision permitting

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[14] *See Rhode Island Med. Soc'y*, 66 F. Supp. 2d at 314-15; *Causeway*, 43 F. Supp. 2d at 613-14; *Miller*, 30 F. Supp. 2d at 1167-68; *Verniero*, 41 F. Supp. 2d at 501-03; *Butterworth*, 54 F. Supp. 2d at 1156; *Jegley*, No. LR-C-97-581, slip op. at 51-61; *Woods*, 982 F. Supp. at 1378.

physicians to rely on their good-faith professional judgment in medical emergencies is constitutionally compelled to avoid the severe and irreparable harm that can result from a physician's hesitation in such circumstances. *See Colautti*, 439 U.S. at 395-96, 401 (statute requiring viability determination and prescribing certain abortion techniques is void for vagueness in part because it does not clearly allow physicians to rely on good-faith judgments); *Voinovich*, 130 F.3d at 204-05 (same, as to statute lacking good-faith provision in its medical emergency exceptions).

For all of these reasons, the Act, even if construed to ban only D&X, subjects women to increased health risks that are both real and wholly unjustified. *See infra* Point III. Because it deprives a woman of her overriding right to have an abortion by the method that best protects her health, the ban is unconstitutional.

III. THE ACT FAILS TO SERVE ANY LEGITIMATE STATE INTEREST.

The Act fails not only the heightened scrutiny that *Casey* and its antecedents mandate for judicial review of restrictions on the right to reproductive choice, but even the minimum rational basis test to which all legislation is subject. It is a fundamental principle of due process that the state must at least have a rational basis for regulating the conduct of individuals. *See Casey*, 505 U.S. at 848 (the "liberty" protected by the Due Process Clause "'includes a freedom from all substantial arbitrary impositions and purposeless restraints'" (quoting *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting))). This principle requires that the Act serve at least some legitimate state interest. Yet Nebraska's ban advances neither of the two interests that the Supreme Court identified in *Casey* -- "interests in the health of the woman and in protecting the potential life

within her," *id.* at 871 -- nor any other legitimate state interest. As Chief Judge Posner concluded in dissent from the Seventh Circuit's decision upholding the Illinois and Wisconsin "partial-birth abortion" bans, the laws "can fairly be described as irrational" and are therefore unconstitutional. *See Hope Clinic*, 195 F.3d at 880 (Posner, C.J., dissenting).

As an initial matter, the Act would not protect women's health; on the contrary, it would seriously threaten their health. *See supra* Point II; *see also Hope Clinic*, 195 F.3d at 878 (Posner, C.J., dissenting) ("The [Wisconsin and Illinois 'partial-birth abortion'] statutes do not seek to protect the lives or health of pregnant women, or of anybody else . . . ."); *Verniero*, 41 F. Supp. 2d at 504 ("The [New Jersey "partial-birth abortion"] Act does not protect the Legislature's legitimate interest in the health of the mother, but rather, poses a threat to the health of the woman." (citation omitted)). That the Act contains no exception to allow a physician to perform a banned procedure when the woman's health is at stake confirms the state's antagonism or, at a minimum, indifference to maternal health. As Chief Judge Posner explained,

> [The bans] are concerned with making a statement in an ongoing war for public opinion . . . . The statement is that fetal life is more valuable than women's health. I do not deny the right of legislatures to enact statutes that are mainly or for that matter entirely designed as a statement of the legislators' values . . . . But if a statute burdens constitutional rights and all that can be said on its behalf is that it is the vehicle that legislators have chosen for expressing their hostility to those rights, the burden is undue.

Hope Clinic, 195 F.3d at 880-81 (citation omitted).

Nor does the ban advance a state interest in preserving fetal life. If, as the state contends, the legislature meant to target only one procedure, Pet'rs' Br. at 22-23, then the government must have intended to steer doctors and patients to alternative methods of abortion. Such a purpose has nothing to do with saving "the lives of fetuses either directly or by seeking to persuade a woman to reconsider her decision to seek an abortion." *Hope Clinic*, 195 F.3d at 878 (Posner, C.J., dissenting); *see also Verniero*, 41 F. Supp. 2d at 504 (holding that New Jersey ban does not serve state interest in potential life because it simply "places the woman in the position of finding another way to obtain an abortion").

In effect conceding, as it must, that the Act serves neither of the state interests this Court has recognized, the state asserts other interests that this Court has never acknowledged as legitimate to support the regulation of abortion. The state posits that the Act serves "a compelling interest in erecting a barrier to infanticide." Pet'rs' Br. at 49. This argument rests on the proposition that the legal status of the fetus changes -- that the fetus approaches personhood -- once a "substantial portion" is delivered from the uterus into the vagina. Yet, as the evidence in this and other cases challenging similar bans shows, in the safest and most common abortion procedures, the physician routinely causes fetal demise only after what may be a "substantial portion" of the fetus has been delivered from the uterus into the vagina. *See supra* Point I. Thus, if the state's theory were correct, the state would be permitted to ban virtually all abortions by recharacterizing them as births in progress -- a result that *Roe* and *Casey* absolutely foreclose. *Casey*, 505 U.S. at 846, 878-79; *Roe*, 410 U.S. at 153, 164; *see* Pet'rs' Br. at 49 (referring to banned procedures as "induced birth process[es]").[15]

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[15] To the extent that the state's argument implies that a "partially born" fetus (continued...)

Moreover, although it is certainly true that Nebraska has a clear and important interest in protecting the life of viable fetuses, nothing in the Act limits the ban's reach to viable fetuses, as the state concedes. *See, e.g.*, Pet'rs' Br. at 48 (conceding that D&X is usually performed prior to viability). In any event, the state's legitimate interest in protecting viable fetuses is already fully served by Nebraska's statute banning post-viability abortion by any method, except when necessary to preserve the woman's life or health. Neb. Rev. Stat. § 28-329 (1995).

Finally, the state asserts interests in preventing cruelty to fetuses, disrespect for potential life, and an erosion of the integrity of the medical profession. Pet'rs' Br. at 48. None of these interests has any basis in the evidence. It is difficult to imagine that a D&X is more painful than a D&E involving dismemberment, *see Eubanks*, 28 F. Supp. 2d at 1042, or that collapsing the fetal skull is more cruel when the fetus is partially outside than when it is wholly inside the uterus, *see Hope Clinic*, 195 F.3d at 879 (Posner, C.J., dissenting). In any event, no evidence suggests that a previable fetus experiences any

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[15](...continued)
is a person entitled to Fourteenth Amendment protection, the implication conflicts with governing precedent. This Court has held that a fetus is not constitutionally protected at any time until it is born alive, *see Roe*, 410 U.S. at 156-62, which does not occur until its "complete expulsion or extraction from [the] mother," *Black's Law Dictionary* 184 (6th ed. 1990). For if the fetus were a constitutional person, *no* abortion (except perhaps a lifesaving one) would be permissible. But, as Justice Stevens has noted, "[N]o Member of the Court has ever questioned th[e] fundamental proposition" that a fetus is not a "person" within the meaning of the Fourteenth Amendment. *Casey*, 505 U.S. at 913 (Stevens, J., concurring). Even the dissenting Members of this Court in *Casey* did not argue that a fetus is a constitutional person. *See, e.g., id.* at 979 (Scalia, J., dissenting) ("The States may, if they wish, permit abortion on demand . . . .").

consciousness of pain. *See, e.g.*, *Voinovich*, 911 F. Supp. at 1074-75.

Instead, these asserted state interests appear to be reflections of repugnance. Repugnance, however, is so limitless a ground for the regulation of abortion as to swallow the established constitutional rights against which the state interests are to be weighed. *See, e.g.*, *Hope Clinic*, 195 F.3d at 879 (Posner, C.J., dissenting) ("No reason of . . . morality that would allow [a concededly constitutionally protected abortion] would forbid [a D&X]."). If the state has license today to enforce a ban on any abortion in which a substantial portion of the fetus is vaginally delivered before the fetus is killed, what prevents it tomorrow from enforcing a ban on any abortion in which the fetal body is in any way disarticulated? Reasonable people may endlessly debate which method is more offensive. Every method of abortion will be outrageous to some and at least unsettling to most. If that alone were sufficient to support bans on various procedures, a woman's right to obtain a safe and legal abortion would soon vanish. Yet *Casey* reaffirms that, in the continuing debate over the morality of abortion, "[t]he destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society" rather than on the dictates of the state. 505 U.S. at 852; *see also Thornburgh*, 476 U.S. at 759 ("'[I]t should go without saying that the vitality of these constitutional principles cannot be allowed to yield simply because of disagreement with them.'" (quoting *Brown v. Board of Educ.*, 349 U.S. 294 (1955))).

In sum, the Act is "not concerned with saving fetuses, with protecting fetuses from a particularly cruel death, with protecting the health of women, [or] with protecting viable fetuses." *Hope Clinic*, 195 F.3d at 880 (Posner, C.J., dissenting). Instead, the Act is essentially concerned with "dramatiz[ing] the ugliness of abortions and deter[ring] physicians from performing

them." *Id.* Because the Act has no purpose other than "to strike at the right itself," it is invalid. *Casey*, 505 U.S. at 874.

CONCLUSION

For these reasons, this Court should affirm the decision of the United States Court of Appeals for the Eighth Circuit invalidating Nebraska's ban on so-called "partial-birth abortion."

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Supreme Court of the United States

DON STENBERG,
Attorney General of the State of Nebraska, *et al.*,

Petitioners,

v.

LEROY CARHART,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF OF AMICI CURIAE RELIGIOUS COALITION FOR REPRODUCTIVE CHOICE, FIFTY-THREE OTHER RELIGIOUS ORGANIZATIONS AND RELIGIOUSLY AFFILIATED ORGANIZATIONS, AND FOURTEEN CLERGY AND LAYPERSONS IN SUPPORT OF RESPONDENT

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INTEREST OF AMICI CURIAE

Amici are religious organizations, religiously affiliated organizations, and individual clergy and laypersons dedicated to preserving religious freedom for all persons, and to protecting a woman's right to terminate her pregnancy in consultation with her religion, values, and conscience.[1] The statements of interest provided by individual organizations, representatives, and individuals, included in Appendix A to this brief, demonstrate their varied perspectives on abortion, and their shared support of the Constitution's protection of a woman's right to make reproductive choices in accord with her individual conscience and free from governmental interference. A full listing of the fifty-four organizations and fourteen individuals signing this brief as amici curiae appears in Appendix B.

Because amici recognize the many divergent theological perspectives regarding abortion, amici agree that all women should be free to follow their religious convictions and to seek the best available medical advice, without governmental coercion or constraint, in making the difficult decision about whether and how to terminate a pregnancy. Amici believe that the Court should not allow

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[1] Amici submit this brief amici curiae with the consent of the parties. Letters providing the consent of the parties are being filed with the Clerk of the Court concurrently with the filing of this brief. Pursuant to Supreme Court Rule 37.6, amici state that the brief in its entirety was drafted by amici curiae and their counsel. No monetary contribution toward the preparation or submission of this brief was made by any person other than amici curiae, their members, or their counsel.

Nebraska or any other state to undermine the Constitution's respect for religious liberty and personal conscience.

SUMMARY OF ARGUMENT

Nebraska's so-called "partial-birth abortion" ban – which drastically curtails access to pre-viability abortions – unacceptably interferes not only with the right to privacy, but also with the freedom of religion and conscience that underlies and defines that privacy right. As the Court explained in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), the right of individual privacy prevents governmental interference into certain of an individual's most critical decisions about family, including whether to marry or divorce, and whether to conceive and bear a child. Those decisions undeniably implicate religious concerns, as they are made and guided by religious teachings and individual conscience. Freedom of religion and conscience, therefore, demands that the utmost latitude be accorded to decisions in the family sphere.

This position is compelled both by the founders' wisdom and the history of the divisive debate on the scope of the right of privacy. The intense debate about abortion in our country, including "partial-birth abortion," has been, and continues to be, driven by profound disagreement among and even within religions. Religious views on the topic range from the belief that abortion is a sin, to the belief that abortion may be a religious obligation under certain circumstances, to the belief that

women must be free to make their own decisions free of governmental interference. A brief examination of the religious beliefs of the different traditions, including the Catholic, Protestant and Jewish traditions, reveals immensely varied views on the issue.

Where religious people have such profound and sincere differences – even within denominations and faith groups – the right of privacy prevents government from enacting restrictive abortion legislation that interferes with the exercise of personal and religious conscience. A woman who is faced with the difficult moral decision of whether to undergo an abortion must be free to decide how to respond, in consultation with her family, her doctor, and her religious beliefs. Nebraska's ban on "partial-birth abortions," Neb. Rev. Stat. §§ 28-326(9), 28-328(1)-(4) [hereinafter "Act"], which is so broad as to ban the safest and most common abortion procedures used prior to viability without any exception for the woman's health, impermissibly interferes with the religious liberty and freedom of conscience that shape the right to privacy.

For this reason, as well as those asserted by respondent, the Court of Appeals for the Eighth Circuit properly held that the Act constitutes an undue burden on a woman's right to terminate a pregnancy prior to viability in violation of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). It is only through semantics and word play that several amici who have filed briefs in support of petitioners contend that *Casey* does not provide the relevant analytical framework. The Act does not regulate the process of "birth," despite the name given to it by its proponents. Nor does it deal with

infanticide. Nor is it a late-term ban. Rather, it is so broadly worded that it bans a range of abortion procedures without regard to fetal viability. That is impermissible under *Casey*, and the Eighth Circuit's judgment should be affirmed in order to afford the vital protection for freedom of conscience in making basic family decisions, which is required by the Constitution.

ARGUMENT

I. THE ACT IMPERMISSIBLY INTRUDES UPON INDIVIDUAL DECISIONS ABOUT FAMILY PROTECTED BY THE RIGHT OF INDIVIDUAL PRIVACY AND RELIGIOUS LIBERTY.

In reaffirming the essential holding of *Roe v. Wade*, 410 U.S. 113 (1973), the Court stated in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), that it is "a promise of the Constitution that there is a realm of personal liberty which the government may not enter." *Id.* at 847. Fundamentally, this promise means that the "Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood." *Id.* at 849. That prohibition on governmental interference includes the freedom to make personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. *Id.* at 851 (citing *Carey v. Population Servs. Int'l*, 431 U.S. 678, 685 (1977)). As the Court observed:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Id. at 851.

The Court also recognized that "[m]en and women of good conscience can disagree . . . about the profound moral and spiritual implications of terminating a pregnancy, even in its earliest stage." *Id.* at 850; *see also Roe*, 410 U.S. at 116 (acknowledging "awareness of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views, even among physicians, and of the deep and seemingly absolute convictions that the subject inspires"). Under those circumstances, the Court recognized that "[o]ur obligation is to define the liberty of all, not to mandate our own moral code." *Casey*, 505 U.S. at 850. Where reasonable people of good conscience disagree, the Court held, government *cannot* adopt the position of one set of persons over all others when doing so would intrude upon a protected liberty. *Id.* at 851 (*citing Texas v. Johnson*, 491 U.S. 397 (1989); *West Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943)).

Thus, as set forth in *Casey*, the right to privacy that protects a woman's right to make her own reproductive choices has two aspects: *first*, the individual's right to make crucial, life-defining decisions free of governmental interference, and *second*, the need for the government not to adopt one position over all others where reasonable persons disagree about decisions of such importance.

The *Roe-Casey* formulation of the right to privacy helps to ensure the religious freedoms guaranteed by the Establishment and Free Exercise clauses. The concerns set forth in *Casey* are precisely the concerns that have motivated the Court's protection for religious liberty under the First Amendment religion clauses. The Court has observed that the constitutional prohibition against legislation "respecting an establishment of religion or prohibiting the free exercise" thereof has a "double aspect." *Cantwell v. Connecticut*, 310 U.S. 296, 303 (1940). "On the one hand, it forestalls compulsion by law of the acceptance of any creed or the practice of any form of worship. Freedom of conscience and freedom to adhere to such religious organization or form of worship as the individual may choose cannot be restricted by law. On the other hand, it safeguards the free exercise of the chosen form of religion." *Id.*

Thus, it is an "individual's freedom of conscience [that is] the central liberty that unifies the various Clauses in the First Amendment." *Wallace v. Jaffree*, 472 U.S. 38, 50 (1985). The "individual's freedom to choose his own creed is the counterpart of his right to refrain from accepting the creed established by the majority." *Id.* at 52. This conclusion "derives support not only from the interest in respecting the individual's freedom of conscience, but also from the conviction that religious beliefs worthy of respect are the product of free and voluntary choice by the faithful." *Id.* at 53. Thus, the Court has held that " '[i]f there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to

confess by word or act their faith therein.' " *Id.* at 55 (quoting *Barnette*, 319 U.S. at 642); *see also School Dist. of Abington Township v. Schempp*, 374 U.S. 203, 226 (1963) ("The place of religion in our society is an exalted one, achieved through a long tradition of reliance on the home, the church and the inviolable citadel of the individual heart and mind. We have come to recognize through bitter experience that it is not within the power of government to invade that citadel . . . .").

Thus, by preserving the right to privacy in *Casey*, the Court also furthers the constitutional objectives that have long been served by the Court's First Amendment religious jurisprudence: Matters of individual conscience require protection from governmental interference, and adoption of one "creed" by the state over all others impermissibly and unconstitutionally impedes the exercise of individual conscience. This overlap is not surprising. For many if not most Americans, the decisions whether to marry or divorce and whether to conceive and bear a child are simultaneously matters of individual choice and religious significance. "These matters, involving the most intimate and personal choices a person may make in a lifetime," *Casey*, 505 U.S. at 851, are by nature shaped by the beliefs an individual holds most sacred. *See also Roe*, 410 U.S. at 116 ("One's philosophy, one's experiences, one's exposure to the raw edges of human existence, one's religious training, one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion."). The Constitution prohibits governmental

interference into crucial family decisions for which individuals look to the guidance of religious teachings and individual conscience.[2] Where reasonable persons of good conscience disagree – as they do when it comes to abortion, *see infra* – the Constitution mandates that the government refrain from imposing one view over all others.

The Court's holding in *Casey*, therefore, that prior to viability, regulations on abortion are permitted only if they do not impose an "undue burden" on a women's ability to decide whether or not to terminate her pregnancy, derives from a woman's right to privacy, but it also protects her freedom of conscience guaranteed by the religion clauses. This Court has properly respected the need for a woman's autonomy in making such decisions, which must be made based on an individual woman's circumstances, her own personal or religious conscience, and the best available medical advice. Thus, the Court's position says that every woman must be free to make decisions about when to have children, according to her

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[2] Historically, of course, the Court's decisions according protection to basic decisions regarding family have drawn significantly on both the First Amendment's guarantees of religious freedom and the right to privacy founded in the Fourteenth Amendment. *See, e.g., Eisenstadt v. Baird*, 405 U.S. 438 (1972) (privacy); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (privacy); *Wisconsin v. Yoder*, 406 U.S. 205 (1972) (free exercise). For example, the Court has guaranteed parents the right to select private, religious schools for their children, *Pierce v. Society of Sisters*, 268 U.S. 510 (1925), and the right to an exemption from compulsory schooling laws where those laws interfered with a particular religious way of life, *Wisconsin v. Yoder*, 406 U.S. 205 (1972).

own conscience and religious beliefs. Nebraska's Act, therefore, violates the sanctity of individual decisions about family life protected by both the right of individual privacy and freedom of conscience.

II. THE VARIETY OF RELIGIOUS VIEWS ABOUT ABORTION PROHIBITS NEBRASKA FROM ENACTING LEGISLATION THAT INTERFERES WITH A WOMAN'S RIGHT TO TERMINATE HER PREGNANCY.

As *Casey* acknowledges (and the Court's First Amendment jurisprudence concurs), where fundamental rights are implicated, it is precisely because reasonable persons of good conscience disagree that the government should refrain from acting. In enacting a ban on "partial-birth abortions," the Nebraska Legislature has violated this basic tenet of constitutional law. The Act is, therefore, unconstitutional.

The diverse religious groups in this country disagree profoundly about abortion. *See Roe*, 410 U.S. at 160.[3] This disagreement is not only over when life begins, but also over whether and how much the government should

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[3] The structure of this discussion is derived in part from the Brief Amicus Curiae for American Jewish Congress, Board of Homeland Ministries – United Church of Christ, National Jewish Community Relations Advisory Council, The Presbyterian Church (U.S.A.) by James E. Andrews as Stated Clerk of General Assembly, the Religious Coalition for Abortion Rights, St. Louis Catholics for Choice, and thirty other religious groups filed in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989).

interfere with a woman's decision to terminate or continue her pregnancy and whether abortion may be required if the mother's life or health is endangered. For example, the official doctrine of the Roman Catholic Church holds that life begins at conception, and declares abortion to be immoral. *See* The Declaration on Abortion of the Sacred Congregation for the Doctrine of the Faith (1974). Some Roman Catholics, however, have explored and advocated religious views that would tolerate abortion under some circumstances. *See, e.g.*, Gregory Baum, "Abortion: An Ecumenical Dilemma," *Commonweal*, Nov. 30, 1973, at 231; *Abortion and Catholicism: The American Debate* (Patricia Beattie Jung & Thomas A. Shannon eds., 1988); Mary C. Segers, "Abortion and the Culture," *in Abortion* 229 (Sidney Callahan & Daniel Callahan eds., 1984). One Catholic organization has recently stated that there "is much in the Catholic tradition that supports the pro-choice position. . . . [A] careful reading of church documents shows that while the prohibition of abortion is a serious teaching, room remains for Catholics to support the legalization of abortion and even its morality in a wide range of circumstances." Catholics for a Free Choice, *Prayerfully Pro-Choice: Resources for Worship* (Religious Coalition for Reproductive Choice 1999).[4]

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[4] According to a recent poll, eighty-two percent of Catholics in this country believe that abortion should be legal either under certain circumstances or without restrictions. Moreover, thirty-nine percent believe that a woman should be able to decide to have an abortion no matter what the reason. Only fifteen percent of Catholics believe that abortion should be illegal in all circumstances. Time/CNN Nationwide Poll (Sept. 27-28, 1995), *cited in* Catholics for a Free Choice, *The Catholic Vote and Abortion*.

In contrast to traditional Catholicism, as a matter of religious belief, many Protestant theologians and scholars maintain that "human personhood . . . does not exist in the earlier phases of pregnancy." *McRae v. Califano*, 491 F. Supp. 630, 701 (E.D.N.Y.), *rev'd on other grounds sub nom. Harris v. McRae*, 448 U.S. 297 (1980); Virginia Ramey Mollenkott, *Respecting the Moral Agency of Women* (undated) ("[T]he fetus is biologically human only in the sense that any part of a human body is human: every cell carries the full genetic code. . . . The full human personhood of the embryo from the moment of conception is therefore a theological assumption that cannot be proved."); Paul D. Simmons, *Personhood, the Bible, and the Abortion Debate* (undated); *Roe*, 410 U.S. at 160 ("There has always been strong support for the view that life does not begin until live birth. . . . It may be taken to represent . . . the position of a large segment of the Protestant community, insofar as that can be ascertained; organized groups that have taken a formal position on the abortion issue have generally regarded abortion as a matter for the conscience of the individual and her family."). Protestant groups disagree, however, about the proper approach to abortion.

The stand of the American Baptist Churches in the USA, for example, reflects the diversity of theological beliefs about abortion present within its membership. In 1988, the General Board adopted a resolution that states: "We grieve with all who struggle with the difficult circumstances that lead them to consider abortion. Recognizing that each person is ultimately responsible to God, we encourage women and men in these circumstances to

seek spiritual counsel as they prayerfully and conscientiously consider their decision." General Board, American Baptist Churches in the USA (1988). The General Board acknowledged that "[m]any of our membership seek legal safeguards to protect unborn life. Many others advocate for and support family planning legislation, including legalized abortion as being in the best interest of women in particular and society in general." *Id.*

The Episcopal Church reaffirmed in its 1994 General Convention its support for women's rights over their own bodies, which was first acknowledged through a resolution in 1967. That Convention expressed "its unequivocal opposition to any legislative, executive or judicial action on the part of local, state or national governments that abridges the right of a woman to reach an informed decision about the termination of pregnancy or that would limit the access of a woman to safe means of acting on her decision." 71st General Convention, Episcopal Church, Resolution No. 1994-A054 (1994). The General Convention explained: "We believe that legislation concerning abortions will not address the root of the problem. We therefore express our deep conviction that any proposed legislation on the part of national or state governments regarding abortions must take special care to see that the individual conscience is respected, and that the responsibility of individuals to reach informed decisions in this matter is acknowledged and honored as the position of this Church." *Id.*[5]

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[5] At their annual meeting in 1978, the Episcopal Women's Caucus resolved: "We are deeply disturbed over the increasingly bitter and divisive battle being waged in legislative bodies to force continuance of unwanted pregnancies and to limit an American woman's right to abortion. We believe that all should be free to exercise their own consciences on this matter and that where widely differing views are held by substantial sections of the American religious community, the particular belief of one religious body should not be forced on those who believe otherwise."

Similarly, the General Synod of the United Church of Christ resolved in 1979 to reaffirm full freedom of choice for the persons concerned in making decisions regarding pregnancy, to affirm "the fact that, since life is less than perfect and the choices that people have to make are difficult, abortion may sometimes be considered," and to affirm that "God calls us when making choices, especially as these relate to abortion, to act faithfully." United Church of Christ, *Abortion, A Resolution of the 12th General Synod of the United Church of Christ* (1979). The General Synod reaffirmed the right of women to choose abortion in 1981, 1985, 1987, 1989, and 1991. In 1987, the 16th General Synod resolved to uphold the "right of men and women to have access to adequately funded family planning services, and to safe, legal abortions as one option among others," and to urge "pastors, members, local churches, conferences, and instrumentalities to oppose actively legislation and amendments which seek to revoke or limit access to safe and legal abortions." United Church of Christ, *Sexuality and Abortion: A Faithful Response, A Resolution of the 16th General Synod of the United Church of Christ* (1987).

With regard to "partial-birth abortion" bans, the Reverend Dr. Jay Lintner, Director, Washington Office, United Church of Christ, has stated: "Let the church and the

religious community offer its advice on this issue, advice to the women facing the choice. Let the medical community offer its advice. But keep the government out of it. Protect the fundamental religious responsibility of a woman to make this decision about her own body and her own responsibility for the developing life within her. This is the overwhelming religious consensus within our church." Rev. Dr. Jay Lintner, *Statement on Partial-Birth Abortions Urging the Senate To Sustain President Clinton's Veto of H.R. 1122* (Sept. 17, 1998).

Some Protestant groups treat abortion as a matter of individual conscience and believe that the government should not interfere in that matter because of the variety of views held by members of these groups. For example, the General Assembly of the Presbyterian Church (U.S.A.) adopted a resolution in 1983, and reaffirmed it in 1985, 1987, 1988, 1989, and 1991, which states that "The Presbyterian Church exists within a very pluralistic environment. Its own members hold a variety of views. It is exactly this pluralism of beliefs which leads us to the conviction that the decision regarding abortion must remain with the individual, to be made on the basis of conscience and personal religious principles, and free from governmental interference." *Covenant and Creation: Theological Reflections on Contraception and Abortion*, Minutes of the 195th General Assembly of the Presbyterian Church 369 (1983). The Presbyterian Church (U.S.A.) believes, therefore, that "[t]he legal right to have an abortion is a necessary prerequisite to the exercise of conscience in abortion decisions. Legally speaking, abortion should be a woman's right because, theologically speaking, making a decision about abortion is, above all, her

responsibility." *Id.* Thus, the Presbyterian Church (U.S.A.) has affirmed that "no law should impose criminal penalties against any woman who chooses or physician who performs a medically safe abortion." Minutes of the 204th General Assembly of the Presbyterian Church (U.S.A.) 372 (1992).

In addition, through its General Assembly, the Presbyterian Church (U.S.A.) has stated that abortions should not be used as a method of birth control, but that abortions later in pregnancy should be an option, particularly in the case of women of menopausal age who do not discover they are pregnant until the second trimester, women who discover through fetal diagnosis that they are carrying a fetus with a grave genetic disorder, or women who did not seek or have access to medical care during the first trimester. *Covenant and Creation: Theological Reflections on Contraception and Abortion*, adopted by the 195th General Assembly of the Presbyterian Church (1983).[6]

Other Protestant churches support a woman's choice regarding abortion because of potential risks to the life or physical or mental health of the mother, because of concerns about the social situation in which the infant might be born, and because of instances of severe deformity of the fetus. *McRae*, 491 F. Supp. at 701 (citing testimony of

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[6] The 209th General Assembly of the Presbyterian Church (U.S.A.) in 1997 refused to call for a ban on the intact D&E procedure, and instead offered "moral guidance" on the subject. That guidance stated that the procedure is "of grave moral concern and should be considered only if the mother's physical life is endangered by the pregnancy."

Reverend John Philip Wogaman, United Methodist minister). The United Methodist Church, for example, believes in the "sanctity of unborn human life," but feels "equally bound to respect the sacredness of the life and well-being of the mother, for whom devastating damage may result from an unacceptable pregnancy." United Methodist Church, *The Book of Discipline of the United Methodist Church* ¶ 65 (1996). The Church maintains that "[g]overnmental laws and regulations do not provide all the guidance required by the informed Christian conscience." *Id.*

Accordingly, the church's General Conference has maintained a stance since 1970 that opposes restrictive abortion legislation. United Methodist Church, *Responsible Parenthood and the Church in Mission* 2 (1992). In 1988, the United Methodist Church resolved further that "We support the legal right to abortion as established by the 1973 Supreme Court decisions. We encourage women in counsel with husbands, doctors and pastors to make their own responsible decisions concerning the personal or moral questions surrounding the issue of abortion." United Methodist Church, *Resolution on Responsible Parenthood* (1988).

The Evangelical Lutheran Church in America stated in 1991 that "there can be sound reasons for ending a pregnancy through induced abortion. . . . We recognize that conscientious decisions need to be made in relation to difficult circumstances that vary greatly." Churchwide Assembly on the Evangelical Lutheran Church in America, Social Teaching Statement on Abortion (1991). The Church therefore believes that it may be morally responsible to terminate a pregnancy where necessary to protect the life of the mother, where pregnancy results from rape

or incest, or where the fetus has severe anomalies that are incompatible with life. *Id.* The Lutheran Women's Caucus resolved in 1990 to affirm that "a woman with an unintended pregnancy deserves the compassionate support of those closest to her, regardless of whether she terminates or continues her pregnancy." Lutheran Women's Caucus, Convocation Gathering (1990).

Within the Jewish tradition, there is considerable agreement that the fetus is not a person before birth, and that abortion is to be permitted, and may even be required in situations where the life of the mother is threatened. David M. Feldman, *Marital Relations, Birth Control, and Abortion in Jewish Law* 271-84 (1986); Raymond A. Zwerin & Richard J. Shapiro, *Abortion: Perspectives from Jewish Traditions* (undated) ("The fetus is not a person; it has no rights."); *see also* Hayim Halevy Donin, *To Be a Jew* 140-41 (1972) ("All halakhic scholars agree that therapeutic abortions – namely, abortions performed in order to preserve the life of the mother – are not only permissible but mandatory."). Beyond this, however, different branches of Judaism, and groups within each branch, hold divergent views about the legal and moral status of abortion and about the circumstances under which it is permitted.

Within the different strands of Orthodox Judaism, for example, there is disagreement as to whether a non-therapeutic abortion is homicide, whether avoiding severe mental anguish of the mother is an adequate basis for permitting an abortion of a fetus with severe defects, and whether it is permissible to include in the choice of an abortion consideration of the potential suffering of a severely disabled fetus carried to term. *See* Feldman,

supra, at 284-94; Donin, *supra*, at 141; Immanuel Jakobovits, "Jewish Views on Abortion," *in Jewish Bioethics* 118 (Fred Rosner & J. David Bleich eds., 1979); J. David Bleich, "Abortion in Halakhic Literature," *in Jewish Bioethics* 134 (Fred Rosner & J. David Bleich eds., 1979).

Conservative, Reform, and Reconstructionist branches of Judaism share a more liberal approach to abortion, and believe that individual women may treat an abortion decision in light of their own religious and moral views. The Central Conference of American Rabbis in 1980 reaffirmed that "Jewish legal literature permits therapeutic abortion," and that the "decision concerning any abortion must be made by the woman and not by the state or any other external agency." Similarly, over 700 Reform rabbis signed a letter in 1998 opposing the federal "partial-birth abortion" ban. That letter states: "As rabbis, we are often called upon to counsel families facing difficult decisions concerning reproductive health choices, including abortion. Like other members of the clergy, we turn to religious law and teachings for guidance in providing such counsel. Judaism has laws governing the issue of abortion, but each case is considered individually. . . . Abortion is a deeply personal issue. Women are capable of making moral decisions, often in consultation with their clergy, families and physicians, on whether or not to have an abortion. We believe that religious matters are best left to religious communities, not politicians." Letter of 729 Rabbis in Support of the President's Veto of H.R. 1122 (Sept. 10, 1998).

The United Synagogue of Conservative Judaism reaffirmed in 1991 that "under special circumstances, Judaism chooses and requires abortion as an act which affirms

and protects the life, well being and health of the mother. . . . [T]o deny a Jewish woman and her family the ability to obtain a safe, legal abortion when so mandated by Jewish tradition, is to deprive Jews of their fundamental right of religious freedom."

Even in these branches, however, authorities differ considerably about the circumstances under which abortion is permitted or required. Some consider abortion to be a religious duty when a pregnancy threatens a woman's life or health. Some would protect a woman's choice to abort simply as a matter of her right to control her own destiny. Morrison D. Bial, *Liberal Judaism at Home: The Practices of Modern Reform Judaism* 12-13 (Rev. ed. 1971). Others emphasize the harm to a woman's physical and emotional well-being that may be caused by a pregnancy as reasons for permitting abortion.

Unitarians have long supported abortion rights. The Unitarian Universalist Association affirmed a woman's right to choose to terminate her pregnancy in 1963 and has consistently reaffirmed that right since then. In 1987, the Association resolved to reaffirm "its historic position, supporting the right to choose contraception and abortion as legitimate aspects of the right to privacy." Unitarian Universalist Association, 1987 General Resolution, *Right to Choose*. Accordingly, in 1993, the Association resolved to urge passage of federal legislation to "guarantee the fundamental right of individual choice in reproductive matters." Unitarian Universalist Association, 1993 General Resolution, *Federal Legislation for Choice*.

It is obvious that many strongly held religious beliefs directly clash with the Act. In some circumstances, the

Act directly interferes with the religious lives of those who are adherents to certain beliefs. For those for whom abortion may be required by their religion in the case of a threat to their life or health, the Act interferes with their choice. For those whose religion dictates that authentic choice is an ethical necessity, the Act negates the freedom of that choice.

Under *Casey*, therefore, Nebraska's Act is unconstitutional. Given the range of beliefs about abortion, the state is not permitted to impose one view as orthodoxy where it would interfere with a fundamental right. By adopting the Act, which as the Eighth Circuit correctly held is so broad as to ban the safest and most common second trimester procedures, Nebraska did precisely what the government must not do under the Constitution. Nebraska has unconstitutionally imbedded into law certain religious beliefs over others. The Act, therefore, unconstitutionally infringes not only on the right to privacy, but also on the right of religious liberty that underlies that right.

III. THE ACT IMPOSES AN UNDUE BURDEN ON THE RIGHT OF WOMEN – RELIGIOUS AND NON-RELIGIOUS – TO DECIDE WHETHER OR NOT TO TERMINATE A PREGNANCY, AND IS THEREFORE UNCONSTITUTIONAL UNDER *CASEY*.

The Act unconstitutionally interferes with a woman's right to make her own decision about whether and when to bear children, in consultation with her husband or partner and her faith. Thus, it was proper for the Eighth Circuit to conclude that the Act imposes an undue burden

on a woman's right to seek an abortion in violation of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). The ban is not limited to "late-term" procedures, nor is it a ban on abortions of viable fetuses. Rather, it effectively bans the safest and most common second trimester abortion procedures. As the Court of Appeals observed, "both the proof and the legal arguments in this case seem to be exclusively about nonviable fetuses." *Carhart v. Stenberg*, 192 F.3d 1142, 1151 (8th Cir. 1999) (20a).[7] Thus, the Act would ban a woman from acting consistently with her religious conscience in making the most personal decision whether to terminate her pregnancy long before viability.

For this reason, in 1996, sixty-nine national religious leaders signed a letter opposing the federal "partial-birth abortion" legislation. In that letter, those leaders stated that:

> We are convinced that each woman who is faced with such difficult moral decisions must be free to decide how to respond, in consultation with her doctor, her family, and her God. . . . [N]one of us can discern God's will as well as the woman herself, and that is where we believe the decision must remain.
>
> Indeed, where religious people have such profound and sincere differences – even within our own denominations and faith groups – the government must not legislate, and thus impose,

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[7] In fact, the evidence in the district court was clear that respondent only performs abortions of non-viable fetuses. 192 F.3d at 1146 (7a); *Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1101 (D. Neb. 1998) (Finding of Fact ¶ 9) (5sa).

> one religious view on all our citizens. To do so violates our most cherished tradition of religious freedom.

Letter to President Clinton from Religious Leaders (Apr. 29, 1996); Laurie Goodstein, "Religious Leaders Back Abortion Ban Veto," *Wash. Post*, Apr. 30, 1996, at A4.

Moreover, the Eighth Circuit properly rejected the argument asserted by amici for petitioners that *Roe* and *Casey* do not apply to the Act because it regulates the "process of birth" rather than abortion. Despite the misleading title of the Act – purporting to ban "partial-birth abortion," a term coined by proponents of the legislation which is *not* a medical term – the Act has nothing to do with "birth." Nor does it have anything to do with preventing infanticide of a "partly born child." The arguments of amici amount to nothing more than semantical word play. Rather, the procedure banned by the Act is defined so broadly that it bans pre-viability abortion procedures, in direct contravention of *Casey*.

The record in this case makes clear that women who choose to terminate their pregnancies do so for a variety of reasons, in light of their own religious convictions and conscience and in keeping with the professional judgment of their physicians. Some health conditions pose serious risks during pregnancy, and those risks may become critical as the pregnancy progresses. Other women seek abortions after learning of severe or fatal fetal anomalies. *See, e.g., Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1113 (D. Neb. 1998) (Finding of Fact ¶ 61) (36sa); *see also* John M. Swomley, "The 'Partial-Birth' Debate in 1998," *The Humanist*, Mar. 1998, at 5; Religious Coalition for Reproductive Choice, *Partial Compassion: Legislative Attacks on Abortion* (undated). The Act unconstitutionally interferes with the ability of those women to exercise their moral and legal rights to make their own judgments about whether and when to bear children, in consultation with their family, their physicians, and their faith.

CONCLUSION

The Court has stated that the "very purpose of a Bill of Rights was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts. One's right to life, liberty, and property, to free speech, a free press, freedom of worship and assembly, and other fundamental rights may not be submitted to vote; they depend on the outcome of no elections." *Barnette*, 319 U.S. at 638. The Court's role in preserving space for religious freedom is never more crucial than when there is massive public turmoil surrounding a subject. Otherwise, majorities, or even effectively mobilized minorities, can invoke the power of the state to curb the religious freedoms of those whose views they do not like. If this role is to mean anything, the Court should preserve a woman's right to terminate her pregnancy consistent with her own personal or religious conscience, and reject Nebraska's attempt to interfere with that right.

For these reasons, and for those stated by respondent, we respectfully urge the Court to affirm the

judgment of the United States Court of Appeals for the Eighth Circuit.

Respectfully submitted,

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APPENDIX A

*Asterisk indicates organization/affiliation/title is for identification purposes only. The organization is not signing on to the brief.

Statement of Interest of the American Friends Service Committee

The American Friends Service Committee (AFSC) has worked since 1917 as a social justice arm of the Religious Society of Friends to root out the causes of violence in our society that lie in poverty, exclusion and denial of equal opportunity and rights and to support rights of conscience. For two decades the AFSC has taken a consistent position supporting a woman's right to follow her own conscience concerning child-bearing, abortion and sterilization, free of coercion including government coercion and the coercion of poverty, racial discrimination and unavailability of services to those who cannot pay.

Statement of Interest of the American Humanist Association

The American Humanist Association (AHA), founded in 1941, has members and affiliates throughout the United States. The AHA affirms the right to privacy and the right of every woman to freedom of conscience and freedom of choice in dealing with problem pregnancies. The AHA has participated as an *amicus curiae* in cases involving freedom of conscience and religious liberty concerns.

Statement of Interest of the American Jewish Committee

The American Jewish Committee (AJC), a national organization of approximately 100,000 members and supporters, was founded in 1906 to protect the civil and religious rights of Jews. AJC believes that this goal can best be achieved by preserving the constitutional rights, including the fundamental right of access to abortion, of all Americans. For this reason, AJC firmly believes that when faced with reproductive health decisions – often in the context of wanted pregnancies gone tragically wrong – women and their families, in consultation with their doctors and in accordance with their religious beliefs, must be able to choose the medical procedure that is safest for the woman and best protects her ability to bear future children.

Statement of Interest of Americans for Religious Liberty

Americans for Religious Liberty (ARL) is a non-profit public interest educational organization dedicated to defending religious liberty, freedom of conscience, and First Amendment rights. ARL has participated as an *amicus curiae* in cases before the Supreme Court and other courts where these concerns have been implicated.

Statement of Interest of the Anti-Defamation League of B'nai B'rith

The Anti-Defamation League of B'nai B'rith (ADL) is a national Jewish human relations organization dedicated to principles of religious and individual liberty including

the right to privacy. ADL views abortion as an issue of personal and religious freedom. Accordingly, it believes that a woman's decision to have an abortion is constitutionally protected, with due regard for the right of women to exercise freely their own religious beliefs and not be constrained by the religious beliefs of others which have been given the sanction of state law. ADL recognizes that various religious faiths and denominations hold divergent views about abortion. In light of this multiplicity of views, ADL believes that no single religious group's beliefs should be legislatively established. Rather, individuals should be permitted broad latitude in deciding for themselves in accordance with their own religious and moral convictions, whether to continue a pregnancy to term. Thus, ADL views most forms of government interference with an individual's exercise of religious conscience on the question of procreative choice, before viability, including those here at issue, to be unconstitutional under the First and Fourteenth Amendments. For these reasons, ADL supports the principles established in *Roe v. Wade*, 410 U.S. 113 (1973), and opposes erosion of the fundamental rights secured by that decision.

ADL has previously filed briefs in this Court in numerous cases dealing with First and Fourteenth Amendment principles, including *Mitchell v. Helms* (1999); *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992); *Webster v. Reproductive Health Services* (1989); *Bowen v. Kendrick* (1988); *Frazee v. Illinois Dep't of Employment Sec.* (1989). Thus, the Anti-Defamation League is able to bring its special expertise relating to religious liberty and its experience advocating religious freedom to the issues raised on this appeal.

Statement of Interest of the Central Conference of American Rabbis

The Central Conference of American Rabbis (CCAR) was founded in 1889. Its members are the body of rabbis who consider themselves and are considered to be the organized rabbinate of Reform Judaism.

Its members consist of Reform Rabbis ordained at the HUC-JIR Hebrew Union College-Jewish Institute of Religion, as well as Reform Rabbis ordained at liberal seminaries in Europe, and some rabbis who joined the Reform movement sometime subsequent to ordination. Most of the latter were ordained either at the Conservative Jewish Theological Seminary or the Reconstructionist Rabbinical College.

At its annual conventions, the Central Conference of American Rabbis has passed several resolutions affirming its pro-choice position. In 1967 the Conference stated: "We strongly urge the broad liberalization of abortion laws in various states, and call upon our members to work toward this end." In 1980, the CCAR reaffirmed this position with the following comments:

> Jewish legal literature permits therapeutic abortion.
>
> The decision concerning any abortion must be made by the woman and not by the state or any other external agency.
>
> We oppose all constitutional amendments and legislation which would abridge or circumscribe this right.

Statement of Interest of Christians for Justice Action

Christians for Justice Action (CJA), a group of clergy and lay activists of the United Church of Christ (UCC), aspires to live out God's call for justice, and to lift up justice concerns within our denomination and society. Our leadership team numbers twenty, and we are supported by approximately 1,400 UCC members.

We hold human life as sacred. We recognize that the choice of whether to bear a child has profound moral weight. We recognize that the function of women in our world goes far beyond the bearing of young, and that the worth of women does not depend on their ability or willingness to bear a child. We believe that there are times and circumstances that can turn a childbirth from a moment of joy and grace to a crisis or tragedy. We believe that the choice to bear young does and should exist, before and after conception. We believe the choice to bring a pregnancy to term or to terminate it belongs with the individual, acting in consultation with those whom she trusts and who demonstrate their care for her without coercion. Therefore Christians for Justice Action reaffirms the Supreme Court ruling of 1973, *Roe v. Wade*, which permits a woman to make a decision regarding abortion based on her own conscience and religious beliefs. Furthermore, we are well aware of a wide range of religious convictions on whether terminating a pregnancy is acceptable. We oppose efforts to enact into law one particular religious doctrine on abortion or the beginning of human life.

In taking this position we stand with the United Church of Christ as a denomination, which voted to recognize a

woman's right to reproductive choice in its 8th General Synod in 1971, and reaffirmed that decision in the 9th General Synod (1973), the 11th General Synod (1977), the 12th General Synod (1979), the 13th General Synod (1981), the 16th General Synod (1987), and the 17th General Synod (1989).

Statement of Interest of the Clergy Advisory Board, Planned Parenthood Federation of America

The clergy members of the Clergy Advisory Board represent a cross section of religious communities in the United States. Their position on the subject of a woman's right to choose to have an abortion stems from the fact there is no uniform theological consensus on this difficult subject. What is consistently held is that a woman should be left to follow her own conscience in dialogue with her God, her physician, and others whose guidance she seeks, to make this most personal decision.

The intervention of any governmental entity to "help" her, or to attempt to persuade or dissuade her in this regard, represents an inexcusable intrusion into what is, without doubt, one of the most intimate, sacred precincts, i.e., "the pursuit of happiness," embodied in the exercise of a person's values in deciding when or whether to bring a child into the world. There can be no compelling interest of the government to interfere in what we the members of the Clergy Advisory Board construe as a woman's right to follow the dictates of her conscience and value system, especially in the absence of a uniform religious consensus on this subject, or a consensus on the part of the American people. Therefore we reaffirm the Supreme

Court ruling of 1973, *Roe v. Wade*, which permits a woman to use her own discretion untrammeled by any other controlling authority in deciding whether to avail herself of this medical procedure.

Statement of Interest of the Clergy Committee of Planned Parenthood Springfield Area

The Clergy Committee of Planned Parenthood Springfield Area, consisting of a variety of religious backgrounds, has wrestled with these issues concerning reproductive choice and human life. We recognize possible conflicts of life with life and through our various faith traditions believe in and support a woman's right to make her own informed choices about contraception and terminating or continuing a pregnancy and to receive safe and proper medical treatment. We hold in high respect the value of potential human life; we do not take the question of choice lightly. In our nation, diverse denominations and faith groups approach the issue of choice from the unique perspective of their own theology, often holding widely varying viewpoints as to when abortion is morally justified. It is exactly this plurality of beliefs which leads us to the convictions that the abortion decision must remain with the individual, to be made on the basis of conscience and personal religious principles, and free from governmental interference. Therefore we reaffirm the Supreme Court ruling of 1973, *Roe v. Wade*, which permits a woman to make a decision regarding abortion based on her own conscience and religious beliefs. We oppose efforts to enact into secular law one particular religious doctrine on abortion or the beginning of human life.

Statement of Interest of the Coordinating Center for Women in Church and Society of the United Church of Christ

The Coordinating Center for Women in Church and Society of the United Church of Christ is a national agency of the United Church of Christ which seeks to "address the concerns of women and work toward the elimination of sexism in church and society." *The Constitution and Bylaws, United Church of Christ*, Paragraph 231.

Recognizing the diversity of religious and theological perspectives on issues related to abortion even within our own denomination, the General Synod of the United Church of Christ has reaffirmed at its meetings in 1979, 1981, 1985, 1987, 1989, and 1991 full freedom of choice for those engaged in decision-making regarding pregnancy as stipulated in *Roe v. Wade*, and has opposed any restrictions that would prevent women from exercising their constitutionally protected individual right to privacy in these matters according to their own conscience and religious beliefs.

We also join as *amicus curiae* to protect the health care of women and the right of their physicians to offer them the safest and most appropriate medical procedures to ensure their health and well-being. These are decisions that should be determined by physicians and their patients, not lawmakers.

Statement of Interest of Disciples for Choice

Disciples for Choice is an organization of members of the Christian Church (Disciples of Christ) and friends of the cause of reproductive choice. The organization numbers

150 and endeavors to maintain the freedom of every woman to decide when to bear children according to her own conscience and religious belief, without governmental interference. Disciples for Choice holds high the dignity of women as responsible decision makers. It also recognizes the diverse approaches to the issue of reproductive choice among the faith groups and denominations. This spectrum of views as to when abortion may be morally justified provides the context which supports the conviction that the individual must make the abortion decision utilizing the guidance of personal faith and counsel. The stance of responsible freedom is supported historically by General Assembly Resolutions #24 (San Antonio, 1975): "Therefore be it resolved that the General Assembly:

1. Affirm the principle of individual liberty, freedom of individual conscience, and sacredness of life for all persons,

2. Respect differences in religious belief concerning abortion and oppose in accord with the principle of religious liberty, any attempt to legislate a specific religious opinion or belief concerning abortion upon all Americans,

3. Provide through ministry of the local congregations, pastoral concern and nurture of persons faced with the responsibility and trauma surrounding undesired pregnancy."

Statement of Interest of the Disciples Justice Action Network

The Disciples Justice Action Network is a network of fifty groups and three hundred individuals and families who are linked together to work for justice in and beyond the Christian Church (Disciples of Christ). Included in the network are the Disciples Peace Fellowship (DPF), the Gay, Lesbian, and Affirming Disciples Alliance (GLAD), Disciples for Choice, Disciples Advocacy Washington Network (DAWN), Light of the World Christian Church, Disciples Witness for Justice (Oklahoma), the Indiana Region of the Christian Church, and forty-three other congregations and groups. We consider the decision about childbirth a religious decision, and primarily the decision of the mother. She must have access to the best and safest medical techniques in either bringing an embryo to birth or aborting the process when that is indicated.

Statement of Interest of Disciples Witness for Justice

Disciples Witness for Justice, a Subcommission of the Christian Church (DOC) in Oklahoma, has been a functioning group addressing peace and justice issues for nearly 20 years. We operate with the following Mission Statement adopted four years ago: Disciples Witness for Justice exercises prayerful discernment under the moral authority of Christ and the Scriptures to help the church seek prophetic action in: (1) Cultivating faith and reason as resources for increasing understanding and integrity as the church answers its call to be God's agent for social change, and (2) Responding to human and social needs especially those of the marginalized and oppressed.

We believe that there are times in people's lives, known only to them, when the advent of an unplanned and unwanted pregnancy presents a crisis beyond measure. Doing justice requires that every person should have access to counseling and medical services necessary for a safe, legal resolution to this crisis. This solution should be in keeping with their religion, values and conscience without government interference.

Statement of Interest of Rev. Lauren D. Ekdahl, Trinity United Methodist Church, Lincoln, Nebraska*

I am writing to express my grave concern that the issue addressed in *Stenberg v. Carhart* will infringe on the right of religious persons, Christian and non-Christian, to hold the belief that human personhood is established at some time other than conception and that the right to a medically safe and legal abortion should be protected for women in our multi-religious democracy. We are not a theocracy. It is wrong to write sectarian notions about the beginning of full personhood into a law that would restrict women in the exercise of their moral agency in accordance with their religious belief when there is no universal consensus among religious traditions on that issue except for full live birth.

In Lincoln, Nebraska, an organization called "Rescue the Heartland" picketed the Westminster Presbyterian Church. I organized clergy of the community to stand in solidarity with Westminster at a press conference supporting the church's decision to retain Dr. Winston Crabb, a physician who performs abortions, on their Board of Elders.

Statement of Interest of the Episcopal Diocese of Newark

The Protestant Episcopal Church in the United States of America (the Episcopal Church) by resolution of General Convention in 1976 set forth the Church's "unequivocal opposition to *any* legislation on the part of national or state governments which would abridge or deny the right of individuals to reach informed decisions (on the matter of abortion) and act upon them." That unequivocal opposition to governmental action abridging the right of individuals to make informed decisions on this matter has been consistently reaffirmed by subsequent actions of the General Convention. In 1981, the Convention of the Diocese of Newark of the Episcopal Church, which I serve as Bishop, adopted a resolution incorporating the identical language as the 1976 General Convention resolution indicating this Diocese' "unequivocal opposition to *any* legislation on the part of national or state governments which would abridge or deny the right of individuals to reach informed decisions [on the matter of abortion] and act upon them." That resolution has similarly been repeatedly reaffirmed by Diocesan Convention in the Diocese of Newark. I strongly support the position of the Episcopal Church both nationally and within the Diocese of Newark in opposing governmental restraints on the free exercise of a woman's right to make reproductive choices for herself.

Accordingly, on behalf of the Diocese of Newark and my own behalf as its Bishop, I ask that we be included among those names as *amicus curiae* in support of Dr. LeRoy Carhart in *Stenberg v. Carhart*.

The Rt. Rev. John Palmer Croneberger

Bishop of Newark

Statement of Interest of Hadassah, the Women's Zionist Organization of America, Inc.

Hadassah, the Women's Zionist Organization of America, is the largest women's and the largest Jewish membership organization in the United States with over 300,000 members nationwide. Founded in 1912, Hadassah is traditionally known for funding and maintaining health care institutions in Israel. However, Hadassah also has a proud history of protecting the rights of women and the Jewish community in the United States, whether by supporting equal rights, freedom of choice, access to health care, or working to eliminate all forms of discrimination against women. Hadassah has a longstanding commitment to supporting and working to protect a woman's right to choose abortion and other reproductive health care services. Hadassah views freedom of choice "as a matter of privacy of the individual to be determined by each woman in accordance with her religious, moral and ethical values."

Tana Senn, National Director, American Affairs/Domestic Policy

Statement of Interest of Jewish Women International

Jewish Women International (JWI) was founded in 1897 as B'nai B'rith Women by a group of Jewish women who sought to improve the quality of life for women in their communities. Now an organization of over 40,000 women

in the United States and Canada, JWI continues to strengthen the lives of women and families through its mission to break the cycle of violence through education, advocacy and action – locally, nationally and around the world. In our work to ensure that women and children live free from violence and abuse, we consider a woman's right to exercise choice over her reproductive rights to be essential to that goal. As Jews, we consider each life to be sacred. However, we affirm the Supreme Court ruling of 1973, *Roe v. Wade*, which permits a woman to make her own choice about abortion based on her own beliefs about when life begins.

Statement of Interest of The Rt. Rev. Edward L. Lee, Jr. of the Diocese of Western Michigan*

As a bishop of the Episcopal Church, I have several concerns about the Nebraska statute. I know that scientists, ethicists, theologians, and other faithful persons differ about the time that life begins, and I worry when states attempt to answer existential question by statute. Similarly, I recognize the decision to have or not to have an abortion is a profound and personal decision to be made by the moral agent involved (that is to say, by the pregnant woman). I must object to any statute which would deny an individual the information and legal right necessary to make an informed decision about her reproductive health or the ability to act upon that decision.

Statement of Interest of the Maine Interfaith Council for Reproductive Choices

The Maine Interfaith Council for Reproductive Choices (MICRC) is a statewide network of pro-choice clergy from diverse traditions, including Episcopalian, Presbyterian (U.S.A.), United Church of Christ, United Methodist, Unitarian Universalist, Reformed Judaism, and Conservative Judaism. Our mission is threefold: to educate our congregations and the larger community about the morality of reproductive choices, to affirm women as moral agents in making reproductive decisions, and to promote public policy that guarantees reproductive freedom.

As religious leaders in Maine, we work in congregations and in the public arena to uphold the fundamental freedom of reproductive privacy and choice expressed in the 1973 Supreme Court decision *Roe v. Wade*. Most recently, MICRC has been a coalition partner in the campaign to defeat a citizen-initiated referendum on "partial birth abortion" that appeared on the November 1999 ballot. In addition to education and advocacy, MICRC offers pastoral counseling services to women (and their partners) who are seeking to make informed, morally responsible choices about reproduction, including the choice to terminate a pregnancy.

Because we recognize, as teachers of faith and morals, that there is a plurality of beliefs about these sensitive matters, we strongly believe that every person should be educated about reproductive options and encouraged to make choices on the basis of sound medical information and in terms of their own religious beliefs and moral values. Moreover, government should not legislate any particular

religious or moral viewpoint about these matters, but rather respect the right and responsibility of women to make their own decisions in light of their faith tradition and ethical values.

Statement of Interest of the Methodist Federation for Social Action

The Methodist Federation for Social Action has been in existence since 1907. We are an independent, nation-wide network of United Methodists committed to providing a fruitful witness to the Gospel of Jesus Christ, working primarily through the ministries of the United Methodist Church. Our 2,000 members are organized into thirty-seven chapters throughout the country. Members work on a wide variety of peace and justice issues including religious liberty, promotion of human rights, non-discrimination, and the empowerment of women. We support reproductive choice.

We affirm the goodness of God's creation and the sacredness of all creation. Therefore, we do not take the question of abortion lightly. We long for a world where abortion is unknown. We envision a world where every child is a wanted child; where family planning and birth control are readily available to and practiced by all the peoples of the world; where adequate nutrition, medical, spiritual, emotional and psychological care is available to all; where meaningful employment and the means to support oneself and one's family are universal; and where adequate prenatal, perinatal, maternal, and child care is available to all. We also recognize that in an imperfect world these goals will never be fulfilled equitably for all people.

Because we regard all life as sacred, we regard the life and well being of the mother to be just as valuable as the potential life of the fetus. We recognize that there are many situations in which more than one of our most deeply held religious and moral values about the sacredness of life will come into conflict with each other. And we recognize that only the individuals most intimately involved in a crisis pregnancy can adequately weigh the factors and values in conflict and come to a decision about the most appropriate course of action. In view of this, we support the right of a woman to choose whether to carry her pregnancy to term, keep her child, give her child up for adoption, or terminate her pregnancy.

The right of reproductive freedom is an issue of religious liberty. Different religious traditions hold widely differing positions on issues related to birth control, pregnancy, abortion, and other issues of reproductive freedom. Because we are guaranteed religious freedom in our Constitution, we believe that reproductive issues ***must*** remain free from government interference. We believe that for secular authority to codify any particular religious tradition or position into law is a violation of the religious liberty of all religious traditions whose teachings differ from that law.

Statement of Interest of Dr. Virginia Ramey Mollenkott, Professor Emeritus, William Paterson University*

According to Scripture, God knew that Adam and Eve would misuse their power to choose. Yet God chose to give them that power, creating them "sufficient to have stood, though free to fall." We human beings should follow our

Creator's example by giving one another moral elbow room. Through the ages, a remarkable number of women have willingly and unselfishly devoted themselves to their children. The way to honor them, and to honor God, is to restrain ourselves from coercion and to seek government policies that support the moral agency of women as well as men, of people of color as well as whites, and of poor people as well as the affluent.

Statement of Interest of The National Council of Jewish Women

The National Council of Jewish Women (NCJW), Inc. is a volunteer organization, inspired by Jewish values, that works through a program of research, education, advocacy and community service to improve the quality of life for women, children and families and strives to ensure individual rights and freedoms for all. Founded in 1893, the National Council of Jewish Women has members in over 500 communities nationwide. Given NCJW's *National Priorities* which state, "We endorse and resolve to work for the protection of every female's right to reproductive choice, including safe and legal abortion, and the elimination of obstacles that limit reproductive freedom," we join this brief.

Statement of Interest of The Rabbinical Assembly

The Rabbinical Assembly, representing more than 1,400 rabbis associated with The Conservative Movement, is pleased to join with other religious organizations in proceedings before the United States Supreme Court in *Stenberg v. Carhart* as an *amicus curiae* in support of Dr. LeRoy

Carhart. The Rabbinical Assembly holds in high respect the value of potential human life. We do not take the question of choice lightly. In our nation, diverse denominations and faith groups approach the issue of choice from the unique perspective of their own theology, often holding widely varying viewpoints as to when abortion is morally justified. It is exactly this plurality of beliefs which leads us to the convictions that the abortion decision must remain with the individual, to be made on the basis of conscience and personal religious principles, and free from governmental interference. Therefore, we affirm the Supreme Court ruling of 1973, *Roe v. Wade*, which permits a woman to make a decision regarding abortion based on her own conscience and religious beliefs. We oppose efforts to enact into secular law one particular religious doctrine on abortion or the beginning of human life.

Since 1983, The Rabbinical Assembly is on record recognizing the permissibility of therapeutic abortion. It has reaffirmed that position subsequently. In addition, since 1985, The Rabbinical Assembly has passed several resolutions in support of *Roe v. Wade*.

Statement of Interest of the Religious Coalition for Reproductive Choice

The Religious Coalition for Reproductive Choice submits this statement of interest in *Stenberg v. Carhart* in accordance with our policies and positions. The Religious Coalition for Reproductive Choice, founded in 1973 as the Religious Coalition for Abortion Rights, is a non-partisan, non-profit education and advocacy coalition of more than 40 national groups. The groups are from 16 denominations

and faith traditions with official statements on reproductive choice, including the Episcopal Church, Presbyterian Church (USA), United Church of Christ, United Methodist Church, Unitarian Universalist Association, and the Reformed, Conservative, and Reconstructionist movements of Judaism. Member groups must meet specific criteria regarding their position on reproductive choice and must be based in a religious tradition.

As the only national coalition of pro-choice people of faith and religious and religiously affiliated organizations, the Religious Coalition for Reproductive Choice supports the moral and legal right of a woman to make her own judgments about whether and when to bear children, in consultation with her husband or partner and her faith. Laws banning abortion and abortion procedures without regard for a woman's life and health fail to respect women as moral decision-makers, in contradiction to the teachings of many religions.

The question of problem pregnancies has been addressed by many religions with many different views and interpretations. In 1996, sixty-nine religious leaders from Religious Coalition member organizations stated: "Where religious people have such profound and sincere differences – even within our own denominations and faith groups – the government must not legislate, and thus impose, one religious view on all our citizens. To do so violates our most cherished tradition of religious freedom."

Given the dramatically contrasting religious views about whether and when abortion is permitted or required, as set out in the *amicus curiae* brief of the Religious Coalition for

Reproductive Choice and other organizations and individuals, state statutes drastically curtailing access to abortion unacceptably interfere with constitutionally protected rights of individual privacy and religious liberty as they apply to critical decisions about the family.

Statement of Interest of the Religious Coalition for Reproductive Choice Affiliates

The following independent organizations, affiliated with the national Religious Coalition for Reproductive Choice, wish to join this brief in support of Dr. LeRoy Carhart: Colorado Religious Coalition for Reproductive Choice, Illinois Religious Coalition for Reproductive Choice, Iowa Religious Coalition for Reproductive Choice, Kentucky Religious Coalition for Reproductive Choice, Maryland Religious Coalition for Reproductive Choice, Massachusetts Religious Coalition for Reproductive Choice, Michigan Religious Coalition for Reproductive Choice, Minnesota Religious Coalition for Reproductive Choice, Missouri Religious Coalition for Reproductive Choice, Nebraska Religious Coalition for Reproductive Choice, New Jersey Religious Coalition for Reproductive Choice, New Mexico Religious Coalition for Reproductive Choice, New York Metro Religious Coalition for Reproductive Choice, New York State Religious Coalition for Reproductive Choice, Northern California Religious Coalition for Reproductive Choice, Ohio Religious Coalition for Reproductive Choice, Oklahoma Religious Coalition for Reproductive Choice, Pensacola Religious Coalition for Reproductive Choice, Southern California Religious Coalition for Reproductive Choice, Washington State Religious Coalition for Reproductive Choice, Western New York

Religious Coalition for Reproductive Choice. Each organization has a multi-faith board of directors that works to ensure reproductive choice and religious freedom.

We hold in high respect the value of potential human life; we do not take the question of choice lightly. In our nation, diverse denominations and faith groups approach the issue of choice from the unique perspective of their own theology, often holding widely varying viewpoints as to when abortion is morally justified. It is exactly this plurality of beliefs which leads us to the convictions that the abortion decision must remain with the individual, to be made on the basis of conscience and personal religious principles, and free from governmental interference. Therefore we reaffirm the Supreme Court ruling of 1973, *Roe v. Wade*, which permits a woman to make a decision regarding abortion based on her own conscience and religious beliefs. We oppose efforts to enact into secular law one particular religious doctrine on abortion or the beginning of human life.

Statement of Interest of the Rt. Rev. Douglas E. Theuner, Bishop of New Hampshire, Episcopal Diocese of New Hampshire*

In conjunction with previous resolutions of the General Convention of the Episcopal Church in the United States of America, I believe that it is imperative to support the right of women to make responsible reproductive choices. This position is not meant to encourage abortion but to allow women to make informed and appropriate choices as to the best opportunities for themselves and any children they might bear.

Statement of Interest of the Union of American Hebrew Congregations

The Union of American Hebrew Congregations is the synagogue arm of the Reform Jewish Movement, which is the oldest and largest Jewish movement in North America. The Union represents 1.5 million Reform Jews and 898 congregations.

Statement of Interest of the Unitarian Universalist Association

The Unitarian Universalist Association is a religious association of more than 1,000 congregations in the United States, Canada and elsewhere. Through its democratic process, the Association adopts resolutions consistent with its fundamental principles and purposes. In particular, the Association has adopted numerous resolutions affirming the principles of separation of church and state and personal freedom on the issue of abortion. Particularly relevant to this case are resolutions of the General Assembly affirming the 1973 decision of the Supreme Court of the United States on abortion and the fundamental right of individual choice in reproductive matters.

Statement of Interest of the United Church Board for Homeland Ministries

The United Church Board for Homeland Ministries is a national agency of the United Church of Christ which addresses mission, evangelism, education and publication.

The United Church Board for Homeland Ministries has supported women's rights to make decisions about when

and if they will become mothers since before the *Roe v. Wade* decision in 1973. The Board passed a resolution supporting reproductive choice in the late sixties and has supported the resolutions of the General Synods of the United Church of Christ in 1971, 1973, 1977, 1979, 1981, 1987 and 1989. Our resolutions are based on our affirmation of the freedom which God has endowed men and women, and the affirmation that this freedom is bound to responsibility. We, also, affirm reverence for life – the life of the mother and the life of the fetus.

Recognizing that the rights of the woman and the rights of the fetus can conflict, we believe that a woman must make the difficult decisions based upon her faith and values. We have opposed any restriction that would prevent women from exercising their constitutionally protected right to privacy. Therefore we join in this *amicus curiae* brief to protect the health care of women and the right of their physicians to offer the safest and most medically appropriate procedures to ensure their health and well being. A decision to terminate a pregnancy needs to be made by the woman in consultation with her physician. No law should restrict a doctor from recommending the safest, most medically appropriate procedures.

Statement of Interest of the United Church of Christ Office for Church in Society

The United Church of Christ is formed of denominations and faith groups who came to America seeking religious freedom. The Congregationalists in New England insisted that each person should formulate their own religious

convictions and each church should formulate its own faith covenant. The United Church of Christ Office for Church in Society was established by the General Synod and mandated to speak out to both church and society on issues of social concern, consistent with the social pronouncements and resolution of the General Synod, the widest and most representative body within the denomination. *Freedom of Reproductive Choice* is perhaps the most widely affirmed statement of the General Synod since the formation of the UCC in 1957, with statements dating back to 1970 by our Office prior to the *Roe v. Wade* decision. Numerous Conferences have passed resolutions, as has the General Synod (which meets every two years) in 1971, 1973, 1977, 1979, 1981, 1985, 1987, 1989 and 1991. The reason for this frequent reaffirmation is that a small minority who disagree with *Freedom of Reproductive Choice* kept putting this back on state and national agendas, only to have the large majority reaffirm this stance. There are a variety of definitions within the UCC as to when life begins, including conception, implantation, quickening, six months, viability, birth. There is considerable consensus that the development of life is a process and that from conception to birth the mother, in consultation with family and doctors, needs to make the decisions for this developing life.

Statement of Interest of Women of Reform Judaism, The Federation of Temple Sisterhoods

Women of Reform Judaism, The Federation of Temple Sisterhoods, including over 100,000 women in 600 local groups nationwide, deeply committed to the social justice teachings of the prophets and the concept of *pikauch*

nefesh, the "value of life," serves humanitarian causes. Women of Reform Judaism has adopted resolutions in support of reproductive rights in 1975, 1977, and 1989, and in 1991 called for support of legislation to provide universal access to health care, including all aspects of reproductive health care, regardless of age, gender and economic status. In support of the Supreme Court decision, *Roe v. Wade*, Women of Reform Judaism has advocated the right of individual women to make a decision regarding abortion based on their conscience and religious beliefs and has opposed efforts, such as the so-called partial birth abortion ban, to redefine or curtail those rights.

Statement of Interest of the Women's Alliance for Theology, Ethics and Ritual (WATER)

The Women's Alliance for Theology, Ethics and Ritual (WATER) is a non-profit education center that seeks to promote religiously informed social change from a feminist perspective. We come from a variety of religious and cultural perspectives, including Catholics, Jews, many Protestant denominations and those who worship Goddesses. We share a commitment to women's well being.

There is a diversity and pluralism among our Alliance colleagues with regard to the question of abortion. We respect those many beliefs and work to hold them in creative tension in a democracy. Hence, we affirm the Supreme Court's decision in 1973, *Roe v. Wade*, which allows women to make the difficult decisions regarding abortion without government interference. We oppose any efforts to change that fundamental right.

We join with the many groups, religious and secular, that seek to make sex education and contraceptives available to all so as to make abortion an infrequent necessity. Meanwhile, we uphold women's reproductive choice as a sacred right.

APPENDIX B

The following is a complete list of organizations and individuals joining this brief as *amicus curiae*:

American Ethical Union
American Friends Service Committee
American Humanist Association
American Jewish Committee
Americans for Religious Liberty
Anti-Defamation League of B'nai Brith
Central Conference of American Rabbis
Christians for Justice Action
Clergy Advisory Board of the Planned Parenthood Federation of America
Clergy Committee of Planned Parenthood Springfield Area
Coordinating Center for Women in Church and Society of the United Church of Christ
Disciples for Choice
Disciples Justice Action Network
Disciples Witness for Justice
Episcopal Diocese of Newark
General Synod of the United Church of Christ
Hadassah
Jewish Reconstructionist Federation
Jewish Women International
Maine Interfaith Council for Reproductive Choices
Methodist Federation for Social Action
Na'amat USA
National Council of Jewish Women
The Rabbinical Assembly
Religious Coalition for Reproductive Choice
including the following affiliates:
Colorado Religious Coalition for Reproductive Choice
Illinois Religious Coalition for Reproductive Choice
Iowa Religious Coalition for Reproductive Choice

Kentucky Religious Coalition for Reproductive Choice
Maryland Religious Coalition for Reproductive Choice
Massachusetts Religious Coalition for Reproductive Choice
Michigan Religious Coalition for Reproductive Choice
Minnesota Religious Coalition for Reproductive Choice
Missouri Religious Coalition for Reproductive Choice
Nebraska Religious Coalition for Reproductive Choice
New Jersey Religious Coalition for Reproductive Choice
New Mexico Religious Coalition for Reproductive Choice
New York State Religious Coalition for Reproductive Choice
Northern California Religious Coalition for Reproductive Choice
New York Metro Religious Coalition for Reproductive Choice
Oklahoma Religious Coalition for Reproductive Choice
Ohio Religious Coalition for Reproductive Choice
Pensacola Religious Coalition for Reproductive Choice
Southern California Religious Coalition for Reproductive Choice
Washington State Religious Coalition for Reproductive Choice
Western New York Religious Coalition for Reproductive Choice
Religious Consultation on Population, Reproductive Health and Ethics
Union of American Hebrew Congregations

Unitarian Universalist Association
United Church Board for Homeland Ministries
United Church of Christ Office for Church in Society
United Synagogue of Conservative Judaism
Women's Alliance for Theology, Ethics and Ritual (WATER)
Women of Reform Judaism, The Federation of Temple Sisterhoods

Individuals (Asterisk indicates organization/affiliation/title is for identification purposes only. The organization is not signing on to the brief.)

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Rev. Lauren D. Ekdahl, Lincoln, Nebraska*
Joseph C. Hough, President of Union Theological Seminary*
Ann Hale Johnson, Chair of the Board, Union Theological Seminary*
The Rt. Reverend Edward L. Lee, Jr.*
The Rt. Rev. Mary Adelia McLeod, Bishop of Vermont, Episcopal Diocese of Vermont*
Reverend Robert Meneilly, Mainstream Coalition*
Dr. Virginia Ramey Mollenkott, Professor Emeritus, William Paterson University*
Rosemary Radford Ruether, Professor of Applied Theology, Garrett-Evangelical Theological Seminary*
The Rt. Reverend Catherine Roskam, Bishop Suffragan of Episcopal Diocese of New York*
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Rt. Rev. Douglas E. Theuner, Bishop of New Hampshire, Episcopal Diocese of New Hampshire*
The Rev. Dr. George D. Younger
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In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF OF AMICUS CURIAE STATE OF CALIFORNIA ATTORNEY GENERAL BILL LOCKYER IN SUPPORT OF RESPONDENT

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QUESTIONS PRESENTED

1. Whether the Eighth Circuit's adoption of a broad unconstitutional reading of Nebraska's ban on partial-birth abortion, which directly conflicts with the narrower constitutional construction of similar statutes by the Seventh Circuit Court of Appeals and that of the state officials charged with enforcement of the statute, violates fundamental rules of statutory construction and basic principles of federalism in contradiction of the clear precedent of this Court?

2. Whether the Eighth Circuit misapplied this Court's instructions in Planned Parenthood v. Casey by finding that a law banning a rare and controversial method of killing a partially-born child, is an "undue burden" on the right to abortion?

LIST OF PARTIES

The Petitioners are Don Stenberg, Attorney General of the State of Nebraska; Gina Dunning, Director of Regulation and Licensure of the Nebraska Department of Health and Human Services; and Charles Andrews, M.D., Chief Medical Officer of the State of Nebraska. An additional Appellant/Defendant below was Mike Munch, Sarpy County Attorney.

The Respondent is LeRoy H. Carhart, M.D.

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INTEREST OF AMICUS

Personal privacy is of utmost importance to California and its citizens. In 1972, before this Court decided *Roe v. Wade*, 410 U.S. 113 (1973), the California electorate added explicit protection of the right of privacy to the California Constitution. Article I, section 1 of the Constitution of the State of California provides that "All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, and privacy."

For nearly twenty years, California courts have held that enumerated right to privacy to protect the fundamental right of California women to choose their procreative destiny. *Committee to Defend Reproductive Rights v. Myers*, 29 Cal.3d 252 (1981). A freedom of choice that under California law predates the explicit inclusion of the right to privacy in Article I, section 1, and this Court's decision in *Roe. People v. Belous*, 71 Cal.2d 954 (1969).

Now, California submits this amicus brief to defend the fundamental privacy right of women to make profoundly personal and moral procreative decisions; decisions fraught with medical complexity; decisions that do not lend themselves to clear statutory distinctions or bright line rules. "The morality of abortion is not a legal or constitutional issue; it is a matter of philosophy, of ethics, and of theology. It is a subject upon which reasonable people can, and do, adhere to vastly divergent convictions and principles." *Committee to Defend Reproductive Rights v. Myers*, 29 Cal.3d 252, 284 (1981).

The issue before this Court does not present a moral choice, it presents a constitutional choice. The impact of the Nebraska statute on the constitutional right to privacy, a right cherished by Californians, is what this Court must decide.

SUMMARY OF ARGUMENT

The Nebraska abortion procedure ban, Neb. Rev. Stat. § 28-326(9), criminalizes a wide range of safe abortion procedures including the safest and most common second-trimester methods. The law violates women's privacy interests and seriously jeopardizes their health and liberty. The statute places a higher value on proscribing a safe medical procedure, than protecting the health of women. In Nebraska, women must either find a physician who will perform a first or second trimester abortion using a less common and less safe method, or they must travel to another jurisdiction to terminate an unwanted or unsafe pregnancy. For some, the Nebraska statute will preclude access to an abortion altogether.

A criminal statute banning any medically safe method of abortion unduly infringes on women's constitutional rights of life, liberty and privacy. There will always be women for whom the banned procedure is medically the safest and most appropriate. Moreover, if a state can ban one medically safe abortion method, it can attempt to ban others. As specific procedures are gradually eliminated, abortion will become increasingly

unavailable and freedom of choice more illusory. Criminalizing safe abortion procedures has the effect of subordinating considerations of women's health to a legislative policy declaration that neither protects fetal life nor public health. For these reasons, the Nebraska abortion statute is unconstitutional, and the judgment of the United States Court of Appeals for the Eighth Circuit should be affirmed.

ARGUMENT

I.

LAWS THAT BAN MEDICALLY SAFE AND APPROPRIATE ABORTION PROCEDURES BUT DO NOT SAFEGUARD HEALTH, MAINTAIN MEDICAL STANDARDS OR PROTECT FETAL LIFE VIOLATE WOMEN'S CONSTITUTIONALLY PROTECTED RIGHT TO PRIVACY

Since this Court decided *Roe v. Wade*, 410 U.S. 113 (1973), the Constitution has protected a woman's right to decide whether or not to terminate her pregnancy before fetal viability. *Roe v. Wade*, 410 U.S. at 153. In the years since *Roe* was decided, the Court has repeatedly reaffirmed this central tenet, even when approving restrictions on abortion. "The woman's right to terminate her pregnancy before viability is the most central principle of *Roe v. Wade*. It is a rule of law and a component of liberty we cannot renounce." *Planned Parenthood v. Casey*, 505 U.S. 833, 871 (1992).

The loss of the right to terminate an unwanted pregnancy inflicts grievous damage on women. Indeed, the *Casey* joint opinion recognized that, with pregnancy, "the

liberty of the woman is at stake in a sense unique to the human condition and so unique to the law." *Casey*, 505 U.S. at 852. Requiring women to sacrifice their liberty in order to enable others to survive imposes a duty on women that has no parallel for men:

> The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist that she make the sacrifice.

Casey, 505 U.S. at 852.

Nebraska seeks to criminalize what it refers to as "partial birth abortion," defined as "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that . . . will kill the unborn child." Neb. Rev. Stat. § 28-326(9); *see Carhart v. Stenberg*, 192 F.3d 1142, 1146 (8th Cir. 1999). The statute prohibits such described abortions at any stage of pregnancy, both before and after viability. As the Circuit court held, the Nebraska statute criminalizes the performance of the dilation and evacuation ("D&E") procedure, as well as a variant of it, the dilation and extraction ("D&X") procedure – the safest and most common methods of abortion in the second trimester.[1] *Carhart*, at 1145. The

[1] Neither the district court nor the Court of Appeals reached the question of whether the statute bans some first-trimester procedures as well as most second-trimester procedures, *see Carhart v. Stenberg*, 192 F.3d 1142, 1145 (8th Cir. 1999) (finding ban unconstitutional because it prohibits the most common second-trimester procedure); *Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1121, 1127 (D. Neb. 1998) (discussing impact of ban on abortions between 16th and 20th week).

Nebraska law thus presents women with a dilemma: they must either find a provider who offers a less common and less safe procedure, or they must find the means to travel to obtain services in a jurisdiction that does not have such restrictions.

This dilemma will severely harm many women. First, it will expose women to unnecessary health risks by eliminating the safest second-trimester procedures. Over the past twenty-five years, D&E abortions have all but replaced previously common induction procedures. The Centers for Disease Prevention and Control attribute the greater reliance on D&E procedures to their lower risk of complications. *See* L. Koonin, et al., Centers for Disease Prevention and Control, *Abortion Surveillance – United States, 1996* at 8 (July 30, 1999).

Eight years ago, this Court observed that medically safe abortion is critically important to women's lives. *See Planned Parenthood v. Casey*, 505 U.S. at 856. This Court has consistently invalidated statutes requiring pregnant women to place their own health at risk for the sake of the fetus, even when the fetus is viable. *See Casey*, 505 U.S. at 846; *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768-69 (1986), *overruled in part on other grounds by Casey*, 505 U.S. at 881-84; *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52, 79 (1975); *Roe*, 410 U.S. at 164-65.

In *Roe v. Wade*, the Court recognized that a "state may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life. At some point in pregnancy, these respective interests become sufficiently compelling to sustain regulation of the factors that govern the abortion decision." *Roe v. Wade*, 410 U.S. at 163.

Here, Nebraska is not seeking to safeguard health, or maintain medical standards. The Nebraska statute does not place a value or importance on women's health, and prohibits the most medically accepted methods of terminating first and second trimester pregnancies. Neither does the statute protect potential life. In dissent, Chief Judge Posner of the Seventh Circuit said about comparable statutes in Wisconsin and Illinois:

> These statutes, remember, are not concerned with saving fetuses, with protecting fetuses from a particularly cruel death, with protecting the health of women, [or] with protecting viable fetuses. . . . They are concerned with making a statement in an ongoing war for public opinion, though an incidental effect may be to discourage some late-term abortions. The statement is that fetal life is more valuable than women's health.

Hope Clinic v. Ryan, 195 F.3d 857, at 880-81 (7th Cir. 1999). The Nebraska legislature's ban on medically preferred abortion methods is so plainly unrelated to the achievement of the goal of protecting fetal life that its true purpose appears unstated.

In this case, both because of the immaturity of the fetus before the twentieth week of pregnancy and because, at least in theory if not in fact, a woman may

still terminate her pregnancy by other less medically accepted methods, fetal survival is not an issue. If states may not sacrifice women's health to protect viable fetal life, such a trade-off is even more impermissible where there is no question of fetal survival. Yet the Nebraska statute requires that women make such a sacrifice.

Most importantly, however, if the state can criminalize one safe abortion method, it could raise questions about whether other methods could also be banned. Indeed, one of the only remaining second-trimester abortion methods, intrauterine saline instillation, has been the target of a statutory ban in the past. *See Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. at 75-76. Such a course would quickly eviscerate *Roe* and *Casey*, as those cases surely do not stand for the proposition that as long as there is one legal abortion procedure that is safe for most women, all others may be banned.

Neither Nebraska nor its *amici* can escape application of *Roe* and *Casey* through a semantic re-casting that evokes images of full-term pregnancy and viability. In no sense is a viable life "born" in any respect, either through a D&E or a D&X procedure. The Nebraska statute itself makes this clear: "Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living *unborn* child. . . . " Neb. Rev. Stat. § 28-326(9) (emphasis added).

Properly framed, the legal question is whether a statute banning medically preferred methods by which a woman may exercise her constitutional right to terminate a pre-viability pregnancy is a valid limitation of that right where the statute does not safeguard health, maintain

medical standards or protect potential life. This issue falls squarely within the interpretive framework of *Casey* and *Roe* and does not present a novel question of fetal rights. As Justice Stevens noted, "The Court in *Roe* carefully considered, and rejected, the State's argument 'that the fetus is a "person" within the language and meaning of the Fourteenth Amendment.' . . . From this holding, there was no dissent; indeed, no Member of the Court has ever questioned this fundamental proposition." *Casey*, 505 U.S. at 913 (quoting *Roe v. Wade*, 410 U.S. 113, 156 (1973)).

CONCLUSION

For all the foregoing reasons *amicus curiae* State of California respectfully request that this Court uphold the judgment of the Court of Appeals for the Eighth Circuit.

Dated: March 28, 2000

Respectfully submitted,

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IN THE SUPREME COURT OF THE UNITED STATES

DON STENBERG,

Attorney General of the State of Nebraska, *et al.*,

Petitioners,

v.

LEROY CARHART,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF *AMICI CURIAE* OF SEVENTY-FIVE ORGANIZATIONS COMMITTED TO WOMEN'S EQUALITY IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICI CURIAE*

Amici Curiae are seventy-five organizations committed to women's rights.[1] *Amici* share a belief that the ability to determine whether and when to bear a child is a central component of women's liberty and equality. This brief is submitted to demonstrate to the Court the ways in which denying women access to safe abortion methods jeopardizes their health, freedom, and equality and to show why statutes banning safe methods of pre-viability abortion unconstitutionally conflict with "the urgent claims of the woman to retain the ultimate control over her destiny and her body, claims implicit in the meaning of liberty." *Planned Parenthood v. Casey*, 505 U.S. 833, 869 (1992).

Individual statements of interest of the *amici* are contained in the Appendix to this brief. Letters from the parties consenting to the filing of this brief have been filed with the Clerk.

SUMMARY OF ARGUMENT

Access to safe and legal methods of abortion has protected women's health and advanced their liberty and equality. The Nebraska abortion procedure ban, *see* Neb. Rev. Stat. § 28-326(9), which criminalizes a wide range of safe abortion procedures including the safest and most common second-trimester procedures, seriously jeopardizes women's health and will deny some women access to abortion altogether. The statute forces women to choose alternative methods of abortion that expose them to unnecessary medical risks. Confronting a highly time-sensitive medical procedure, women subject to the Nebraska ban either must find a physician who will perform an abortion using a less common and less safe method or they

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[1] Counsel for a party did not author this brief in whole or in part. No person or entity, other than the *amici curiae*, their members, or counsel, made a monetary contribution to the preparation or submission of this brief.

must travel to a jurisdiction without a procedure ban. For some women, these hurdles will be insurmountable, precluding access to an abortion altogether.

The Nebraska procedure ban will harm any woman subject to it, but its impact will be harshest on the most vulnerable women. In particular, women who seek the second-trimester procedures encompassed within the statutory ban are likely to be those women who have been unable to obtain earlier abortions because they suffer under special burdens such as poverty, health problems, domestic violence, or youth. A substantial number of these particularly vulnerable women will lose access to abortion altogether.

A criminal statute banning *any* medically safe method of abortion unduly infringes upon women's rights even if drawn more narrowly than the Nebraska statute at issue in this case. There will always be women for whom the banned procedure is safest and best. Most importantly, if a state can ban one safe abortion method, it is likely to ban others. As procedures are eliminated, abortion by any method will become increasingly unavailable. Upholding the Nebraska statute will thereby permit opponents of women's reproductive liberty to accomplish piecemeal what pre-*Roe* statutes accomplished outright.

In addition to violating women's privacy rights, statutes banning safe abortion procedures inescapably implicate the Constitution's promise of liberty and equality. For women, full-term pregnancy and childbirth result in tremendous bodily intrusions and significant physical risks and pain. As the Court has recognized, compelled childbirth and motherhood limit women's life choices and burden the participation of women as equals in society. To force women to make these sacrifices against their will violates their bodily integrity, deprives them of autonomous control of their lives, disadvantages them economically, and imposes upon them burdens that have no parallel for men.

Furthermore, the fetal rights theories advanced in support of Nebraska's ban do not justify the harm the ban inflicts on women. Criminalizing safe abortion procedures out of

concern for the fetus subordinates women's health to fetal interests and could lead to nightmarish state interference with the liberty of pregnant women. The notion advanced by Petitioners and their *amici* that nonviable fetuses accrue constitutionally protectible "locational" rights as the result of being aborted finds no support in law or reason and expresses profound disrespect for the bodily integrity of the whole woman. For these reasons, the Nebraska abortion ban is unconstitutional, and the judgment of the United States Court of Appeals for the Eighth Circuit should be affirmed.

ARGUMENT

I. LAWS BANNING SAFE ABORTION METHODS JEOPARDIZE WOMEN'S HEALTH AND WILL IMPEDE WOMEN'S ACCESS TO ABORTION.

A. Medically Safe Abortion Has Protected Women's Health and Autonomy and Advanced Women's Economic and Social Status.

As this Court noted only eight years ago, medically safe abortion has been critically important to women's lives. *See Casey*, 505 U.S. at 856. It has improved women's health dramatically, both by reducing injuries and deaths inflicted by non-medical or self-induced procedures[2] and by saving women from the devastation of uncontrolled childbearing. As a consequence, women's general health has benefited. *See* Gerald N. Rosenberg, *The Hollow Hope* 355 (1991) (stating that legalized abortion has removed "serious health hazards" for women).

The legalization of abortion has permitted women to participate more fully in society. Since abortion was legalized, women have made unprecedented strides in

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[2] Between 1973, the year *Roe v. Wade*, 410 U.S. 113 (1973), was decided, and 1985, women's rate of death from abortion fell more than eight times, from 3.4 deaths per 100,000 in 1973 to 0.4 deaths per 100,000 in 1985. Rachel B. Gold, Alan Guttmacher Institute, *Abortion and Women's Health: A Turning Point for America?* 28 (1990).

employment and education[3] as they have gained a significantly greater capacity to make personal choices outside of the traditional maternal role and attained positions of leadership in every field of endeavor. It is not coincidental that women's entry in large numbers into occupations previously held exclusively by men came on the heels of this Court's recognition of the right to reproductive privacy: these advances would have been impossible if women had not had the ability to time and limit their childbearing. In Justice Blackmun's words,

> [b]ecause motherhood has a dramatic impact on a woman's educational prospects, employment opportunities, and self-determination, restrictive abortion laws deprive her of basic control over her life.

Casey, 505 U.S. at 928 (Blackmun, J., concurring in part and dissenting in part).

Even more fundamentally, the availability of safe and legal abortion has made it possible for a woman to take "autonomous charge of her full life's course." Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe v. Wade, 63 N.C. L. Rev. 375, 383 (1985). Indeed, "[a]n entire generation has come of age free to assume *Roe*'s concept of liberty in defining the capacity of women to act in society, and to make reproductive decisions." *Casey*, 505 U.S. at 860. As the *Casey* Court

[3] There has been a substantial increase in women's representation in the labor force and a diminution in the persistent wage gap between men and women. *See* Women's Bureau, U.S. Dep't of Labor, *20 Facts on Women Workers* (last modified Mar. 2000) <www.dol.gov/dol/wb/public/wb_pubs/20fact00.htm> (documenting significant increases in the proportion of women in the labor force between 1900 and 1990 and noting that women are expected to constitute 48% of the labor force by 2005); Economic Policy Institute, *Workforce Diversity Increases* (visited Mar. 24, 2000) <www.epinet.org/webfeatures/snapshots/archive/071499/shapshots071499.html>; *see also* Victor R. Fuchs, *Women's Quest for Economic Equality*, 3 J. Econ. Persp. 36-37 (1989); *Women's Work, Men's Work: Sex Segregation on the Job* 23-24 (Barbara F. Reskin & Heidi I. Hartmann eds., 1986).

explained, reproductive decisions are among the most important decisions any person can make:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Id. at 851; *see also id.* at 916 (Stevens, J., concurring in part and dissenting in part) ("The authority to make such traumatic and yet empowering decisions is an element of basic human dignity. . . . [A] woman's decision to terminate her pregnancy is nothing less than a matter of conscience."). The denial of the abortion right is a denial of the most fundamental liberty, akin to the denial of women's personhood.

B. The Nebraska Abortion Procedure Ban Imposes Substantial Obstacles to Safe, Pre-Viability Abortions.

The Nebraska abortion ban will unravel much of the progress women attained in the post-*Roe* era, particularly for women who are seeking any of several accepted and commonly performed abortion procedures. As the United States Court of Appeals for the Eighth Circuit held, the Nebraska statute criminalizes the performance of the dilation and evacuation (D&E) procedure, as well as a variant of it, the dilation and extraction (D&X) procedure—the safest and most common methods of abortion in the second trimester.[4]

[4] Neither the district court nor the Court of Appeals reached the question of whether the statute bans some first-trimester suction curettage procedures as well as most second-trimester procedures. *See Carhart v. Stenberg*, 192 F.3d 1142, 1145 (8th Cir. 1999) (finding ban unconstitutional because it prohibits the most common second-trimester procedure); *Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1130 n.44 (D. Neb. 1998) (declining to reach whether statute affects suction curettage). Nor did the courts below determine whether the statute bans second-

Carhart v. Stenberg, 192 F.3d 1142, 1145 (8th Cir. 1999). The Nebraska law thus places a significant impediment in women's path by increasing the delay, expense, and physical risk they must endure in order to obtain an abortion. Either they must find the means to travel to a jurisdiction that does not have such restrictions and attempt to find a provider there in time to have an abortion,[5] or they must find an in-state

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trimester induction procedures. The statute's plain language and the record evidence would support such findings. *See* Brief *Amici Curiae* of the American College of Obstetricians & Gynecologists et al. at Part I.B.1. n.23 [hereinafter Br. ACOG]. Indeed, courts in other jurisdictions considering similar statutes have found that these procedures are also swept up by such bans. *See Planned Parenthood v. Miller*, 30 F. Supp. 2d 1157, 1165-67 (S.D. Iowa 1998) (suction curettage), *aff'd*, 195 F.3d 386 (8th Cir. 1999); *Planned Parenthood v. Verniero*, 41 F. Supp. 2d 478, 493 (D.N.J. 1998) (suction curettage and induction), *appeal argued*, No. 99-5042 (3d Cir. Nov. 19, 1999); *A Choice for Women v. Butterworth*, 54 F. Supp. 2d 1148, 1155-56 (S.D. Fla. 1998) (induction); *Little Rock Fam. Plan. Servs. v. Jegley*, No. LR-C-97-581 (E.D. Ark. Nov. 13, 1998) (same), *aff'd*, 192 F.3d 794 (8th Cir. 1999); *Planned Parenthood v. Alaska*, No. 3AN-97-6019 CIV, slip op. at 17 (Alaska Super. Ct. Mar. 13, 1998) (suction curettage); *Planned Parenthood v. Woods*, 982 F. Supp. 1369, 1378 (D. Ariz. 1997) (induction). That Nebraska's ban may reach some first-trimester abortions and all but the most dangerous and invasive second-trimester procedures renders it even more egregious. The Court need not reach this issue, however, because a ban on D&E and D&X procedures is itself unconstitutional. *See* Br. ACOG, *supra*, at Part II.

[5] Several district courts that have considered abortion procedure bans have found that travel presents a serious obstacle to women who need an abortion. *See, e.g., Rhode Island Med. Soc'y v. Whitehouse*, 66 F. Supp. 2d 288, 314 (D.R.I. 1999) (finding that ban constitutes an undue burden because it would force women to travel to providers in other states, resulting in increased delay and danger for women), *appeal stayed*, No. 99-2095 (1st Cir. Nov. 22, 1999); *Richmond Med. Ctr. for Women v. Gilmore*, 11 F. Supp. 2d 795, 809-10 (E.D. Va. 1998) (in finding that abortion ban would force women to suffer irreparable harm, recounting doctor's testimony about patients who would have to go out of state to seek care and would be subject to greater risk because of delay), *stay granted on other grounds*, 144 F.3d 326 (4th Cir. 1998); *Summit Med. Assocs. v. James*, 984 F. Supp. 1404, 1417 (M.D. Ala. 1998) (finding that ban would require travel out of state which would increase delay and cost, resulting in an increased risk to the woman and the possibility of

provider who uses a less common and less safe abortion method that remains legal.

Women with the ability to leave the state will face a separate set of hurdles in locating a provider. Despite projections that 43% of American women will have at least one abortion during their childbearing years,[6] in Nebraska and throughout the United States, there is a well-documented shortage of abortion providers.[7] The provider shortage is directly related to the climate of violence and stigma created by opponents of the procedure.[8] Like Dr. Carhart himself,[9]

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completely losing access to abortion), *aff'd in part and rev'd in part on other grounds*, 180 F.3d 1326 (11th Cir. 1999), *cert. denied*, 68 U.S.L.W. 3565 (U.S. Mar. 6, 2000); *Woods*, 982 F. Supp. at 1373 ("If second-trimester abortions were not available in Tucson, many of the patients of Kino Hospital would not be able to obtain a second-trimester abortion because they do not have the means to travel outside of Arizona.").

[6] *See* Stanley K. Henshaw, *Unintended Pregnancy in the United States*, 30 Fam. Plan. Persp. 24, 29 (1998).

[7] Dr. Carhart is the only doctor in Nebraska who performs abortions past sixteen weeks' gestation. *Carhart*, 11 F. Supp. 2d at 1102. Nor is Nebraska an unusual case. Only 14% of counties in the United States have any abortion provider at all. *See* Stanley K. Henshaw, *Abortion Incidence and Services in the United States, 1995-1996*, 30 Fam. Plan. Persp. 263 (1998). The percentage of abortion providers who offer second-trimester procedures diminishes rapidly with every passing week of gestation: 48% of providers offer abortion services at thirteen weeks of gestation but only 13% offer abortions at twenty-one weeks. *See* Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, 27 Fam. Plan. Persp. 54 (1995).

[8] *See* U.S. General Accounting Office, Report to the Ranking Member, Subcommittee on Crime, Committee on the Judiciary, House of Representatives, *Abortion Clinics: Information on the Effectiveness of the Freedom of Access to Clinic Entrances Act* 2 (Nov. 1998) (describing climate of increasing violence directed at reproductive health care providers); National Abortion Federation, *Incidents of Violence and Disruption Against Abortion Providers* (last modified Nov. 1999) <www.prochoice.org/violence/99vd.html> (annual statistics on murders, attempted murders, arsons, bombings, and chemical attacks against abortion providers).

[9] Dr. Carhart was the victim of anti-choice violence in 1991 when his family's home and barn were burned to the ground. *See* Tamra

providers of second-trimester procedures are typically targets of the most extreme and dangerous anti-choice violence and terrorism.[10] Accordingly, even women with the means to travel to states without procedure bans will face difficulties in quickly finding a provider of second-trimester procedures.

Women who are unable to travel out of state may well find their access to any method of abortion foreclosed as a result of the ban. A sweeping criminal statute prohibiting virtually all second-trimester procedures is likely to deter physicians from offering any second-trimester procedures and may drive still greater numbers of providers out of practice. *See* David A. Grimes, *Clinicians Who Provide Abortions*, 80 Obstetrics & Gynecology 719, 721 (1992) (noting that "[h]arassment and intimidation may dissuade skilled clinicians from entering this field, or convince them to quit"). Thus, for women who cannot travel to obtain the required procedure due to financial constraints or medical complications, Nebraska's ban will effectively eliminate their ability to have a safe abortion by shrinking the already constricted pool of available providers. Some of these women will be reduced to attempting illegal or self-induced procedures or will be forced to carry the pregnancy to term. That is precisely the "choice" that *Roe* forbids.

The few women who may succeed in finding a provider in Nebraska will face unnecessary health risks from less safe procedures.[11] Over the past twenty-five years, D&E

Fitzpatrick, *Abortion-Rights Supporters Lament Decline in Clinics*, Dallas Morning News, Oct. 4, 1997, at 43A.

[10] *See, e.g.*, *Nuremberg Files: Abortionists on Trial* (visited Mar. 24, 2000) <www.geocities.com/CapitolHill/Parliament/1735/aborts.html>.

[11] In blatant disregard of this Court's command, *see Casey*, 505 U.S. at 846 (requiring even post-viability abortion restrictions to contain a health exception), the Nebraska ban has no provision making an exception for the health or safety of the pregnant woman. Chief Judge Richard Posner of the United States Court of Appeals for the Seventh Circuit expressed his dismay at a similar flaw in statutes enacted by Illinois and Wisconsin: "It is incomprehensible to me why these states, if acting in good faith, were unwilling to write the same health exception into statutes that criminalize the abortion of nonviable as well as viable fetuses." *Hope Clinic v. Doyle*, 195 F.3d 857, 879 (7th Cir. 1999) (Posner, C.J., dissenting), *petition for cert. filed*, U.S.L.W. daily ed. Jan. 20, 2000 (U.S. Jan. 10, 2000) (No. 99-1152). In addition, although the Nebraska ban contains a narrow exception for women whose lives are endangered, *see* Neb. Rev. Stat. § 28-328(1), that part of the statute is also constitutionally deficient. *See* Brief of *Amici* American Civil Liberties Union et al. at Part II; Br. ACOG, *supra* note 4, at Part IV.

abortions have all but replaced previously common induction procedures.[12] The Centers for Disease Control and Prevention attribute the greater reliance on D&E procedures to their lower risk of complications. *See* Centers for Disease Control & Prevention, *Abortion Surveillance–United States, 1996*, 48 Morbidity & Mortality Wkly. Rep. (No. SS-4) 8 (1999) [hereinafter *Abortion Surveillance*]; *see also* Brief *Amici Curiae* of the American College of Obstetricians & Gynecologists et al. at Part II.B.1. [hereinafter Br. ACOG] (discussing relative safety of abortion methods).

This Court has consistently invalidated statutes requiring pregnant women to place their own health at risk for the sake of the fetus, even when the fetus is viable. *See Casey*, 505 U.S. at 846; *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 768-69 (1986), *overruled in part on other grounds by Casey*, 505 U.S. at 881-84; *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52, 79 (1975); *Roe v. Wade*, 410 U.S. 113, 164-65 (1973). In this case, fetal survival is not at issue because of the immaturity of the fetus before the twentieth week of pregnancy. Surely, if the state's interest in viable fetal life is insufficient to require a woman to sacrifice her health, the state cannot exact that sacrifice for less. Yet the Nebraska state demands just that.

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[12] From 1974 to 1996, the percentage of second-trimester abortions performed by D&E increased from 31% to 93%, and the percentage of second-trimester abortions performed by intrauterine saline or prostaglandin instillation declined sharply, from 57% to 2%. *See* Centers for Disease Control & Prevention, *Abortion Surveillance–United States, 1996*, 48 Morbidity & Mortality Wkly. Rep. (No. SS-4) 8 (1999). Similarly, the percentage of hysterectomy and hysterotomy abortions declined from 10% to 0.4% and from 0.6% to less than 0.01%, respectively. *See id.*

Furthermore, the weight of the Nebraska ban will fall most heavily on precisely those women least able to bear it: disadvantaged women who are already encumbered by circumstances making it difficult to obtain an abortion promptly. Only a small percentage of abortions take place in the second trimester. *See Abortion Surveillance*, *supra*, at 5 (finding that 88% percent of abortions are obtained in first trimester and only 10% in the second trimester). A mere 4% of abortions are obtained at sixteen to twenty weeks, the period of gestation during which Dr. Carhart performs most of his D&X abortions. *See Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1105 (D. Neb. 1998). Women who obtain abortions after the very earliest stages of pregnancy typically face special circumstances or difficulties that delay them. For example, in some cases, fetal abnormalities are discovered through testing undertaken in the second trimester. In other cases, socioeconomic factors play a significant role in delaying the abortion into the second trimester. These factors include: poverty, which prevents low-income women from raising the money quickly enough to pay for an earlier procedure;[13] domestic violence, because abusers often deter their victims from getting an earlier abortion;[14] unawareness

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[13] First-trimester abortions cost roughly $300. Henshaw, *Factors Hindering Access*, *supra* note 7. Second-trimester procedures are even more expensive. In 1995-96, non-hospital facilities charged on average $604 for an abortion at sixteen weeks of gestation and $1,067 at twenty weeks. *Id.* That cost well exceeds the entire maximum monthly welfare allowance for a family of three. *See* Comm. on Ways & Means, U.S. House of Reps., *1998 Green Book* 415-17 (1998) (in 1997, median maximum grant was $377; Nebraska maximum grant was $364). Moreover, Nebraska does not fund abortions for low-income women, although the state's refusal to provide Medicaid funding for abortions for rape and incest survivors has been held to violate the Hyde Amendment. *See Orr v. Nelson*, 902 F. Supp. 1019, 1019 (D. Neb. 1994), *aff'd*, 68 F.3d 479 (8th Cir. 1995). Poor women in Nebraska hence face the daunting task of raising a considerable sum of money quickly, and the sum they must raise compounds with each week of delay.

[14] *See Carhart*, 11 F. Supp. 2d at 1113 (testimony of Dr. Stubblefield that "women who are finally deciding to leave their abusive spouse" are among those likely to get second-trimester abortions); *see also* Susan S. Glander et al., *The Prevalence of Domestic Violence Among Women*

of pregnancy that can often stem from youth;[15] an unforeseeable change in circumstances such as a health problem[16] or desertion by a spouse or partner[17] that occurs only after several months of pregnancy; and inability to locate or access a provider.[18] Race is also correlated with post-first-trimester procedures:[19] Black women are 2.8 times more likely to obtain a second-trimester abortion than are white women. *Abortion Surveillance*, *supra*, at 7.

In addition, the cumulative effect of the barrage of abortion restrictions adopted by most of the states in the post-*Casey* era has been to delay non-emergency abortions, often

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Seeking Abortion, 91 Obstetrics & Gynecology 1002, 1003 (1998) (finding that 39.5% of women seeking abortion self-reported a history of abuse); G. Evins & N. Chescheir, *Prevalence of Domestic Violence Among Women Seeking Abortion Services*, 6 Women's Health Iss. 204 (1996) (noting that 22% of women seeking abortion identified history of abuse within the past calendar year). As this Court noted in *Casey*, a significant number of women seeking abortions are domestic violence victims. *See Casey*, 505 U.S. at 893 (discussing relationship between abortion and domestic violence); *id.* at 888-92 (recounting trial court's record about domestic violence).

[15] More than one-third of all abortions after twelve weeks are obtained by teenagers. National Abortion Federation, *Abortion After Twelve Weeks* (visited Mar. 25, 2000) <www.prochoice.org/facts/after12w.htm>; *see also Carhart*, 11 F. Supp. 2d at 1113 (setting forth testimony of Dr. Stubblefield that youth is one of many factors delaying abortions into second trimester).

[16] "Women having an abortion later in pregnancy were also more likely to report personal health problems [or] possible fetal health problems . . . ." Janet E. Gans Epner et al., *Late-Term Abortion*, 280 JAMA 724, 725 (1998); *see also Carhart*, 11 F. Supp. 2d at 1113 (recounting testimony of Dr. Stubblefield that health complications are a factor leading to second-trimester abortions).

[17] Henshaw, *Unintended Pregnancy*, *supra* note 6, at 25 (initially desired pregnancies are sometimes terminated for reasons including loss of partner or lack of support).

[18] *See* discussion *supra* notes 5 & 7.

[19] This result is related to the higher rates of poverty among Black women, who are five times more likely to live in poverty than are white women. Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* 111 (1997).

substantially. *See* Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, 27 Fam. Plan. Persp. 54 (1995) (discussing impact of state waiting periods, physician-only counseling requirements, parental notification and consent laws, and public funding restrictions on access to abortion); *see also* Ted Joyce & Robert Kaestner, *The Impact of Mississippi's Mandatory Delay Law on the Timing of Abortion*, 32 Fam. Plan. Persp. 4, 7 (2000) (finding that, following implementation of mandatory delay law, proportion of second-trimester abortions in Mississippi increased by 53% among women whose closest provider was in-state). With existing restrictions delaying women into the second trimester, abortion procedure bans such as Nebraska's close off second-trimester options and thus result in the practical elimination of the right to abortion. Because the loss of access to legal abortion will most directly affect the most vulnerable women, this Court should look particularly searchingly at the statute in question. The Nebraska statute is more than a "particular burden" unfairly targeting disadvantaged women, *see Casey*, 505 U.S. at 887. For women unable to obtain early abortions, the ban will amount to a substantial obstacle by sharply decreasing their access to second-trimester procedures and providers.

Nor does the fact that some women will continue to have access to safe abortion methods render the Nebraska ban constitutional. *Amicus Curiae* National Right to Life Committee argues that the Nebraska ban is not an undue burden because it would prevent no more than 1/19th to 2/19ths of Dr. Carhart's patients from getting a D&X procedure. *See* Brief *Amici Curiae* of the National Right to Life Committee et al. at 24. In addition to leaving out of this equation the D&E procedures that the statute also criminalizes, this "rights-by-numbers" approach was firmly repudiated by *Casey*:

> The analysis does not end with the one percent of women upon whom the statute operates; it begins there. Legislation is measured for consistency with the Constitution by its impact on those whose conduct it affects. . . . The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant.

Casey, 505 U.S. at 894 (striking down husband notification provision affecting 1% of Pennsylvania women seeking abortions). Here, for many of the women who need D&E or D&X abortions during the stage in pregnancy at which these banned methods are commonly used, the Nebraska statute will function as an absolute obstacle. *Roe* and *Casey* permit no such result.

Even if the Nebraska ban could be narrowed to reach only D&X abortions,[20] it would still impermissibly harm women. There are some women for whom the D&X procedure is best for safety and other health-related reasons. *See Carhart*, 11 F. Supp. 2d at 1126; Br. ACOG, *supra*, at Part II.B.1. (discussing health benefits of D&X abortions, including accurate diagnosis of fetal anomalies and opportunity for grieving pregnancy loss). For these women, a judicially narrowed statute would not cure the constitutional defect: rather, it would remain an undue burden on their right to abortion by denying them the procedure that is most medically advisable for them. In the constantly evolving practice of obstetrical medicine, the Nebraska ban will also foreclose the refinement of new techniques needed to develop safer procedures for the future, thus unduly burdening all women's right to the development of the safest abortion procedures. *See id.* at Part III. In any event, criminalizing procedures that closely resemble other common procedures will chill the performance of the other procedures as well.[21]

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[20] It is improper for the Court to rewrite state statutes by inserting words to save their constitutionality. *See Reno v. American Civil Liberties Union*, 521 U.S. 844, 884-85 (1997); *Marchetti v. United States*, 390 U.S. 39, 60 n.18 (1968).

[21] Indeed, that is the purpose of the ban, and that improper purpose dooms the statute to unconstitutionality under the purpose prong of the undue burden test. *See* Brief *Amici Curiae* of the National Abortion and Reproductive Rights Action League et al. at Part II.

More importantly, if states can go so far as to criminalize safe methods of pre-viability abortion to show concern for fetuses, states may very well attempt to enact successive bans on other safe abortion methods. Indeed, one of the only remaining second-trimester abortion methods, intrauterine saline instillation, has been the target of a statutory ban in the past. *See Danforth*, 428 U.S. at 75-76.[22] Surely, *Roe* and *Casey* do not stand for the proposition that as long as one safe abortion procedure is legal, all others may be banned.

II. LAWS BANNING SAFE ABORTION METHODS DEPRIVE WOMEN OF LIBERTY AND EQUALITY.

Pregnancy, childbirth, and motherhood demand of women extraordinary physical, psychological, and financial commitments. Because maternity is so consuming, a woman's liberty is acutely impaired when she is forced into it:

> The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist that she make the sacrifice.

Casey, 505 U.S. at 852. Indeed, the *Casey* Court observed that, with pregnancy, "the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law." *Id.*

Unwanted pregnancies and ill-timed childbearing heavily burden the participation of women as equals in society. *See* Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. Pa. L. Rev. 955 (1984) (describing physical, economic, and social burdens). The Nebraska ban, by prohibiting the safest abortion methods and impeding access to providers, will

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[22] As discussed *supra* note 4, the vagueness of the statutory language leaves unclear whether the saline induction method is always or sometimes criminalized by the Nebraska ban.

compel some women to bear children against their will, curtailing their ability to choose a different role and in this way depriving them of the choices and opportunities available to men. As this Court noted in *Casey*,

> [f]or two decades of economic and social developments, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail. The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.

Casey, 505 U.S. at 856.

Not only do such laws deprive women of the autonomy necessary for their liberty and equal participation in society, but requiring women to make these sacrifices for the sake of others imposes a duty on women that has no parallel for men. This Court repeatedly has held unconstitutional federal and state laws that "den[y] women, simply because they are women, full citizenship stature–equal opportunity to aspire, achieve, participate in and contribute to society . . . ." *United States v. Virginia*, 518 U.S. 515, 532 (1996) (citing *Kirchberg v. Feenstra*, 450 U.S. 455, 462-63 (1981), and *Stanton v. Stanton*, 421 U.S. 7 (1975)).

That it is women alone at whom restrictions on abortion are directed and that women alone bear the burdens and disadvantages of coerced pregnancy and childbirth has led commentators to explore the implications of abortion restrictions for women's equality under a number of constitutional theories. *See* Ginsburg, *Some Thoughts on Autonomy and Equality*, *supra*, at 382-83; Law, *Rethinking Sex*, *supra*; Laurence H. Tribe, *American Constitutional Law* § 15-10, at 1353 (2d ed. 1988); Reva Siegal, *Reasoning From the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 Stan. L. Rev. 261 (1992); David A. Strauss & Cass R. Sunstein, Brief *Amicus Curiae* National Coalition Against Domestic Violence Supporting Appellees, *Webster v. Reproductive Health Services*, *reprinted in* 11 Women's Rts. L. Rep. 281 (1989).

As discussed by these commentators, in addition to implicating women's Due Process right to privacy, some restrictions on abortion may constitute sex discrimination prohibited by the Equal Protection Clause.[23] In analyzing the impact of abortion restrictions on constitutional guarantees of gender equality, Justice Blackmun discussed the gender stereotypes underlying such restrictions:

> By restricting the right to terminate pregnancies, the State conscripts women's bodies into its service, forcing women to continue their pregnancies, suffer the pains of childbirth, and in most instances, provide years of maternal care. The State does not compensate women for their services; instead, it assumes that they owe this duty as a matter of course. This assumption—that women can simply be forced to accept the "natural" status and incidents of motherhood—appears to rest upon a conception of women's role that has triggered the protection of the Equal Protection Clause.

Casey, 505 U.S. at 928 (Blackmun, J., concurring in part and dissenting in part) (citing *Mississippi Univ. for Women v.*

[23] Nebraska's abortion ban also violates the Fourteenth Amendment's Citizenship Clause because it "abridge[s] the privileges or immunities of citizens of the United States . . . ." U.S. Const. amend. XIV, § 1. In *Saenz v. Roe*, 526 U.S. 489, 119 S. Ct. 1518 (1999), this Court breathed new life into that clause by finding that the right to travel was protected by an individual's "status as a citizen of the United States." 119 S. Ct. at 1526. Looking at the right to travel as the model of the rights guaranteed by the Citizenship Clause, the clause must at a minimum protect "the basic right that genuine citizenship presupposes—the right to individual self-government . . . ." Laurence H. Tribe, *Comment:* Saenz *Sans Prophecy: Does the Privileges or Immunities Revival Portend the Future – or Reveal the Structure of the Present?*, 113 Harv. L. Rev. 110, 183 (1999). As described by the Court in *Casey*, restrictions on abortion such as Nebraska's infringe upon just that right: "The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." *Casey*, 505 U.S. at 586.

Hogan, 458 U.S. 718 (1982), and *Craig v. Boren*, 429 U.S. 190 (1976)).[24]

Indeed, in an evolving line of cases, this Court has refused to permit states to use "the common-law understanding of a woman's role within the family," *Casey*, 505 U.S. at 897, as the justification for unequal treatment:

> There was a time, not so long ago, when a different understanding of the family and of the Constitution prevailed. . . . Only one generation has passed since this Court observed that "woman is still regarded as the center of home and family life," with attendant "special responsibilities" that precluded full and independent legal status under the Constitution. These views, of course, are no longer consistent with our understanding of the family, the individual, or the Constitution.

Id. at 896-97 (citing *Hoyt v. Florida*, 368 U.S. 57, 62 (1961)). Out of respect for the enormous sacrifices motherhood demands, the *Casey* Court specifically rejected using abortion restrictions to enforce sex-role stereotypes:

> Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's

[24] This Court's jurisprudence does not foreclose an Equal Protection analysis of abortion restrictions. *See Jane L. v. Bangerter*, 61 F.3d 1505, 1517 n.11 (10th Cir. 1995) (in context of challenge to restrictive abortion statute, finding that *Geduldig v. Aiello*, 417 U.S. 484 (1974), and *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263 (1993), are "distinguishable" and "do not preclude the development of an abortion jurisprudence rooted in the Equal Protection Clause"), *rev'd on other grounds*, *Leavitt v. Jane L.*, 518 U.S. 137 (1996); *see also* Deborah A. Ellis, *Re-Examining Gender Scrutiny: A Symposium Discussion: Protecting "Pregnant Persons": Women's Equality and Reproductive Freedom*, 6 Seton Hall Const. L.J. 967, 969-72 (1996) (criticizing *Geduldig* and arguing that *Bray*'s dissenters offer better view of *Geduldig*'s narrow holding); Paula Abrams, *The Tradition of Reproduction*, 37 Ariz. L. Rev. 453, 495-97 (1995) (arguing that *Geduldig* reinforced cultural stereotypes defining women by their reproductive function); Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. Pa. L. Rev. 955, 983 n.107 (1984) (collecting scholarly criticism of approach and result of *Geduldig*).

> role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.

Id. at 852; *cf. UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 211 (1991) ("It is no more appropriate for the Courts than it is for individual employers to decide whether a woman's reproductive role is more important to herself and her family than her economic role.").

Far from justifying restrictions on women's liberty, legislative efforts to require conformity with sex-role stereotypes have been repeatedly rejected by this Court. *See, e.g.*, *Miller v. Albright*, 523 U.S. 420, 443 (1998) (assuming for purpose of analysis that if the classification "were merely the product of an outmoded stereotype, it would be invalid"); *id.* at 452 (O'Connor, J., concurring) (stating that gender classifications based on stereotypes are unlikely to survive heightened scrutiny); *id.* at 472 (Breyer, J., dissenting) (noting that majority of Court agrees that gender classifications based on stereotypes are unlikely to survive heightened scrutiny); *Hogan*, 458 U.S. at 25-26 (invalidating policy reflecting "archaic and stereotypic notions" of the "proper roles of men and women"); *Stanton v. Stanton*, 421 U.S. 7, 14-15 (1975) (invalidating statute because of its assumption that women are "destined solely for the home and the rearing of the family, and only [men] for the marketplace and the world of ideas"); *see also* David H. Gans, *Notes: Stereotyping and Difference:* Planned Parenthood v. Casey *and the Future of Sex Discrimination Law*, 104 Yale L.J. 1875 (1995) (discussing the role of stereotypes in Supreme Court gender equality jurisprudence).

It is plain that no legitimate governmental objectives are advanced by the inequality perpetrated by the Nebraska procedure ban. Unless Nebraska concedes that its ban prevents some women from obtaining abortions altogether, it cannot claim that the statute protects fetal life.[25] As Chief

[25] As Chief Judge Posner noted, "[i]f any fetal lives are saved by these statutes, it will only be by scaring physicians away from performing

Judge Posner wrote about comparable statutes in Wisconsin and Illinois:

> These statutes, remember, are not concerned with saving fetuses, with protecting fetuses from a particularly cruel death, with protecting the health of women, [or] with protecting viable fetuses. . . . They are concerned with making a statement in an ongoing war for public opinion, though an incidental effect may be to discourage some late-term abortions. The statement is that fetal life is more valuable than women's health.

Hope Clinic v. Doyle, 195 F.3d 857, 880-81 (7th Cir. 1999) (Posner, C.J., dissenting), *petition for cert. filed*, U.S.L.W. daily ed. Jan. 20, 2000 (U.S. Jan. 10, 2000) (No. 99-1152). In fact, the statute's true purpose is to advance an impermissible state interest of expressing hostility to legal abortion generally and to most second-trimester abortions specifically. *See* Brief *Amici Curiae* of the National Abortion and Reproductive Rights Action League et al. at Part II. Such a state purpose, "designed to strike at the right itself," *Casey*, 505 U.S. at 874, cannot justify restrictions on women's abortion rights. *See id.* at 876 (citing *Roe*, 410 U.S. at 162).

Comparing Nebraska's ban to Pennsylvania's informed consent law is instructive. In *Casey*, the joint opinion recognized that a state may "express[] a preference for childbirth over abortion." *Id.* at 883. If in fact the Nebraska statute can be said to "express[] a preference for childbirth over abortion," it does so not by informing women that it disapproves of their choices, but by actually interfering in the exercise of their protected rights. In contrast, the preference expressed in the Pennsylvania informed consent provision at issue in *Casey* was upheld because, based on the limited record before it, the Court deemed it to "further [the state's]

any [] abortions . . . ." *Hope Clinic*, 195 F.3d at 878 (Posner, C.J., dissenting).

legitimate goal of protecting the life of the unborn by . . . ensuring a decision that is mature and informed." *Id.*[26]

The Nebraska abortion procedure ban furthers no such goal. To require women to sacrifice their health and equality for what is at best a purely symbolic state interest in "show[ing] concern for the life of the unborn," *see* Br. Pet'rs at 48, and at worst a purposeful attempt to frustrate women's exercise of their constitutional rights flies in the face of settled law holding women's health and autonomy inviolate: "[I]f a statute burdens constitutional rights and all that can be said on its behalf is that it is the vehicle that legislators have chosen for expressing their hostility to those rights, the burden is undue." *Hope Clinic*, 195 F.3d at 881 (Posner, C.J., dissenting).

III. NO STATE INTEREST IN FETAL PROTECTION AND NO THEORY OF INDEPENDENT FETAL RIGHTS JUSTIFIES THE HARM INFLICTED ON WOMEN BY THE NEBRASKA ABORTION PROCEDURE BAN.

In the past, despite the constitutional and statutory protections that should have prevented such abuses, women's liberty has frequently been constricted to protect perceived fetal interests. This Court has recognized, for example, that "[c]oncern for women's existing or potential offspring historically has been the excuse for denying women equal employment opportunity." *Johnson Controls,* 499 U.S. at 211 (invalidating under Title VII a "fetal protection" policy banning all potentially fertile women, not just pregnant

[26] Because *Casey* involved a facial challenge to the Pennsylvania Abortion Control Act, the Court left open the possibility that this and the other restrictions would, on a different record, be invalidated should they prove unduly burdensome to women's abortion right. *See Casey*, 505 U.S. at 888 (upholding waiting period "on the record before [the Court]"); *id.* at 926 (Blackmun, J., concurring in part and dissenting in part) ("the joint opinion has not ruled out the possibility that these regulations may be shown to impose an unconstitutional burden"); *id.* at 992 (Scalia, J., concurring in part and dissenting in part) (undue burden standard "may ultimately require the invalidation of each provision upheld today").

women, from well-paying jobs that exposed them to toxic substances); *see also Goesaert v. Cleary*, 354 U.S. 464 (1948) (prohibiting women from bartending); *Muller v. Oregon*, 208 U.S. 412 (1908) (upholding maximum work-hour restrictions for women only).[27]

That concern also has led courts in a different context to force women to undergo unwanted surgery for the purported benefit of their fetuses. *See, e.g., In re A.C.,* 533 A.2d 611 (1987) (ordering cesarean section, over woman's objection, even though the surgery hastened her death from cancer), *vacated and remanded*, 573 A.2d 1235 (D.C. 1990); *Jefferson v. Griffin Spaulding County Hosp. Auth.*, 247 S.E.2d 457 (Ga. 1981) (overriding pregnant woman's decision and ordering involuntary cesarean); *see also* Veronika Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 New Eng. J. Med. 1192 (1987) (citing courts in eleven states that have ordered women to submit to unwanted cesarean surgery). In addition, states have used their civil child abuse and criminal justice systems to intrude deeply into women's decisionmaking during pregnancy. *See, e.g., In re Valerie D.,* 613 A.2d 748 (Conn. 1992) (invalidating application of civil child abuse statute to pregnant woman's drug use invalidated); *People v. Stewart,* No. M508197 (San Diego Cal., Mun. Ct. Feb. 23, 1987) (involving criminal prosecution of pregnant woman based in part on failure to obtain timely obstetrical care); *Whitner v. South Carolina*, 492 S.E.2d 777 (S.C. 1997) (allowing prosecution of pregnant women for child abuse under state law), *cert. denied*, 118 S. Ct. 1857 (1998); *Ferguson v. City of Charleston*, 186 F.3d 469 (4th Cir. 1999) (restricting pregnant women's Fourth Amendment rights under guise of fetal protection), *cert. granted*, 68 U.S.L.W. 3550 (U.S. Feb. 28, 2000) (No. 99-936); Lynn M. Paltrow, *Pregnant Drug*

[27] As recently as 1968, thirty-eight states limited women's work hours and prohibited overtime with its attendant higher rate of pay; eighteen states barred women from night work; and twenty-six states excluded women from some occupations entirely, such as mining and bartending. Ann E. Freedman, *Sex Equality, Sex Difference and the Supreme Court,* 92 Yale L.J. 913, 920 n.27 (1983).

Users, Fetal Persons, and the Threat to Roe v. Wade, 62 Alb. L. Rev. 999 (1999) (discussing prosecution of pregnant women for child abuse).

If the Court upholds the Nebraska ban and permits states to advance their purported concern for fetuses by restricting pregnant women's access to safe abortion procedures, states would be emboldened to invade virtually any personal decision made by a woman that affects her pregnancy. Indeed, in invalidating a husband-notification provision of Pennsylvania's abortion law, the *Casey* Court discussed the ramifications of permitting an interest in the potential life of the fetus, in that case the husband's interest, to outweigh a woman's liberty:

> Perhaps next in line would be a statute requiring pregnant married women to notify their husbands before engaging in conduct causing risks to the fetus. After all, if the husband's interest in the fetus' safety is a sufficient predicate for state regulation, the State could reasonably conclude that pregnant wives should notify their husbands before drinking alcohol or smoking . . . before using contraceptives or before undergoing any type of surgery that may have complications affecting the husband's interest in his wife's reproductive organs. . . . A state may not give to a man the kind of dominion over his wife that parents exercise over their children.

Casey, 505 U.S. at 898.

Similarly, here, a decision upholding the Nebraska ban could encourage states to deny women necessary medical treatment if that treatment might threaten fetal development. States might prohibit any number of activities or conditions during pregnancy, *e.g.*, failing to maintain appropriate weight, not exercising in moderation, not having a nutritious diet, failing to "stay off her feet," smoking, drinking alcohol, ingesting caffeine, suffering physical harm, taking various prescription drugs, or failing to get adequate prenatal care or

strictly follow physicians' advice.[28] Under the guise of fetal rights,

> [because] anything which a pregnant woman does or does not do may have an impact, either positive or negative, on her developing fetus, any act or omission on her part could render her liable to her subsequently born child. . . . Any action which negatively impacted on fetal development would be a breach of the pregnant woman's duty to her developing fetus. Mother and child would be legal adversaries from the moment of conception until birth.

Stallman v. Youngquist, 531 N.E.2d 355, 359 (Ill. 1988). Such minute state oversight of pregnant women's actions would give the state the kind of dominion over a woman that this Court has refused to confer on her husband. *See Casey*, 505 U.S. at 898.

The pernicious effect that the Nebraska ban will have on women's legal status is predictable in light of the theories out of which the legislation developed. *See, e.g.*, James Bopp, Jr. & Curtis R. Cook, *Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence*, 14 Issues L. & Med. 3 (1998) (setting forth theory that *Roe* and *Casey* do not apply to bans such as Nebraska's). Although this Court properly chose to deny *certiorari* on this question, several of the *amici* writing in support of Nebraska contend that *Roe* and *Casey* do not control this case because they addressed "unborn"

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[28] *See, e.g.*, L.C. Castro et al., *Maternal Tobacco Use and Substance Abuse: Reported Prevalence Rates and Associations With the Delivery of Small for Gestational Age Neonates*, 81 Obstetrics & Gynecology 396 (1993) (discussing effect of smoking on fetal development); L.P. Finnegan & S.R. Kandall, *Maternal and Neonatal Effects of Alcohol and Drugs, in Substance Abuse, A Comprehensive Textbook* 513, 529 (J.H. Lowinson et al. eds., 1997) (discussing prenatal effects of alcohol); *Merck Manual of Diagnosis and Therapy* 1859-61 (R. Berkow ed., 16th ed. 1992) (discussing prenatal effects of thyroid medications, antihypertensive drugs, and aspirin); C. Chazotte et al., *Cocaine Use During Pregnancy and Low Birth Weight: The Impact of Prenatal Care and Drug Treatment*, 19 Seminars in Perinatology 293 (1995) (discussing value of prenatal care for pregnancy).

children, not the "partially born." *See, e.g.*, Brief of *Amici Curiae* U.S. Rep. Charles T. Canady et al. at 20-21 [hereinafter Br. Rep. Canady]; Brief *Amicus Curiae* of the United States Catholic Conference et al. at 8-15. Nebraska likewise makes this distinction in passing in its main brief, *see* Br. Pet'rs at 49, and more fully in its petition for *certiorari*. Pet. Cert. at 12-16. The distinction, according to Petitioners and their *amici*, is that the nonviable fetus acquires "locational" rights by virtue of its extraction from the uterus and its "partial birth." *See, e.g.*, Br. Rep. Canady, *supra*, at 24 ("[I]t is on the basis of the child's change in *location* that governments may assert a distinct compelling interest in protection of human life in the process of birth."); Br. Pet'rs at 49.

Neither Nebraska nor its *amici* can escape application of *Roe* and *Casey* through a semantic re-casting of this Court's precedent that evokes images of full-term pregnancy and viability. Through either a D&E or a D&X procedure, in no sense and in no part is a viable life "born." *See* Br. ACOG, *supra*, at Part I.A. n.19 (distinguishing "birth" and "abortion"). The Nebraska statute itself makes this clear by acknowledging that the fetus remains "unborn" during the process: "Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living *unborn* child . . . ." Neb. Rev. Stat. § 28-326(9) (emphasis added).

Properly framed, the legal question is whether a statute banning safe methods by which a woman's constitutional right to terminate a pre-viability pregnancy is realized places a substantial obstacle in the path of the exercise of that right. This issue falls squarely within the interpretive framework of *Casey* and *Roe* and does not present a novel question of fetal rights. As Justice Stevens noted,

> [t]he Court in *Roe* carefully considered, and rejected, the State's argument "that the fetus is a 'person' within the language and meaning of the Fourteenth Amendment." . . . From this holding, there was no dissent; indeed, no Member of the Court has ever questioned this fundamental proposition.

Casey, 505 U.S. at 913 (Stevens, J., concurring in part, dissenting in part) (quoting *Roe*, 410 U.S. at 156).

The argument of Nebraska and its *amici* amounts to this: a woman's right to privacy extends to the uterus but not the passage from the uterus. Thus, Nebraska and its *amici* would use this case as an opportunity to accord nonviable fetuses a new set of rights, attaching in the course of the woman's exercise of her constitutional right to abortion, that displace the woman's. In essence, by exercising her right to choose abortion, the woman loses rights as the fetus gains them. There is perhaps no quicker way to eviscerate the right to terminate a pregnancy than to give fetuses rights that arise by virtue of the termination.

The "locational" rights theory has grave ramifications for women's health as well. Banning abortion procedures involving extraction of the fetus through the woman's vagina will leave only methods involving invasive abdominal surgery (such as hysterectomies and hysterotomies) or possibly labor induction (such as saline or prostaglandin instillation), all of which are rare, medically riskier, and substantially more painful than the banned procedures. *See* Br. ACOG, *supra*, at Facts 2 (describing different abortion procedures). Such a price to terminate a pregnancy is unconstitutionally steep. *See Danforth*, 428 U.S. at 78-79.

As is evident from the devastating consequences that flow from it, the "locational" fetal rights theory is at its root profoundly degrading to women. The notion that a uterus is private whereas the adjacent vaginal canal is not may only be credited by ignoring that these body parts belong to a whole woman, whose privacy rights protect all of her. Nothing in constitutional jurisprudence establishing the framework of individual rights and competing state interests suggests that women can be fragmented into certain body parts that are imbued with rights and certain others that the state may invade to serve its interests. The locational rights theory ignores the fact that it is the individual whole woman who possesses constitutional rights, not her separate body parts.

Such a fragmentation of constitutional rights within a woman's body is an idea profoundly at odds with constitutional precedent and basic human dignity and equality.

CONCLUSION

For all the foregoing reasons as well as those contained in the Brief for Respondents, *amici curiae* respectfully request that this Court affirm the judgment of the United States Court of Appeals for the Eighth Circuit.

Respectfully submitted,

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APPENDIX
INDIVIDUAL STATEMENTS OF INTEREST OF *AMICI CURIAE*

ABORTION ACCESS PROJECT

The Abortion Access Project is an organization of activists and health care providers seeking to increase awareness of abortion as a critical part of comprehensive reproductive health services, address the shortage of abortion providers, and ensure access to abortion for all women.

ACCESS PROJECT

The Access Project is dedicated to expanding women's access to reproductive choice by integrating early abortion into primary medical care. The Project trains primary care physicians and other health care providers in medical abortions and Manual Vacuum Aspiration and works to remove economic and bureaucratic obstacles to providing early abortions in primary care settings.

ALAN GUTTMACHER INSTITUTE

The Alan Guttmacher Institute (AGI) is an independent, nonprofit corporation that provides research, policy analysis, and education in reproductive health. AGI's mission is to protect and expand the reproductive choices of all women and men in freedom and dignity. AGI supports laws and policies that enable individuals everywhere to have access to the information and services they need to exercise their rights and responsibilities concerning sexual activity, reproduction, and family formation.

ALLEGHENY REPRODUCTIVE HEALTH CENTER

The Allegheny Reproductive Health Center has been providing quality reproductive health care in Pennsylvania since 1975. Over 4,000 women and men visit the clinic annually for medical services, counseling, and education.

ALLENTOWN WOMEN'S CENTER

The Allentown Women's Center, founded in 1978, is the largest first-trimester abortion provider located in Northeastern Pennsylvania. The Allentown Women's Center is committed to maintaining the highest standards of the medical field while providing medical care and emotional support to women coping with problem pregnancies. The Allentown Women's Center values advocacy as highly as the delivery of abortion services and is committed to women freely and knowingly making decisions regarding their bodies.

AMERICAN ASSOCIATION OF UNIVERSITY WOMEN

For over a century, the American Association of University Women (AAUW), an organization of 150,000 members, has been a catalyst for the advancement of women. In more than 1,500 communities across the country, AAUW members work to promote education and equity for all women and girls, lifelong learning, and positive societal change. AAUW plays a major role in activating advocates nationwide on AAUW's priority issues, including gender equity in education, reproductive choice, social security, and workplace and civil rights issues.

AMERICAN JEWISH CONGRESS

The American Jewish Congress, an organization of American Jews founded in 1918, is dedicated to the protection of the civil liberties and civil rights of Jews and all Americans and the promotion of the principles of constitutional democracy. The American Jewish Congress believes that, in the face of the great moral and religious diversity in American society over abortion and in the light of Jewish traditions which in some cases command abortion and in many others, permit it, the existing constitutional

rules, set down in *Roe v. Wade*, should be maintained so that the different traditions may advocate their respective views and the decision left to the individual woman, answering to God and to her conscience.

AMERICANS FOR DEMOCRATIC ACTION

Americans for Democratic Action, Inc. (ADA) is an independent liberal political organization, founded in 1947, dedicated to promoting individual liberty and economic justice. ADA publishes a weekly legislative newsletter for liberal activists, a quarterly newsletter, special reports, including an annual voting record report that ranks Members of Congress based on a full spectrum of domestic and international policy issues. ADA also engages in independent campaign activity in support of Presidential candidates.

ASIANS AND PACIFIC ISLANDERS FOR REPRODUCTIVE HEALTH

Asians and Pacific Islanders for Reproductive Health (APIRH) is dedicated to improving the reproductive health and freedom of Asians and Pacific Islanders nationally, including insuring access to a full range of reproductive health services. Through education, advocacy, community-based research, and community organizing, APIRH has worked for the reproductive health and freedom of its communities since 1989.

BAR ASSOCIATION OF SAN FRANCISCO

The Bar Association of San Francisco (BASF) is the second-largest voluntary bar association in California, numbering over 9,500 members. BASF has a long and distinguished tradition of commitment to equality of opportunity, irrespective of income, for racial and ethnic

minorities, women, gay men and lesbians, people with disabilities, and others who have historically been the victims of discrimination. As an integral component of that commitment, the Association has historically stood in strong support of the Constitutional right of a woman to choose whether or not to have an abortion and has deemed governmental intrusion impermissible.

BOSTON WOMEN'S HEALTH BOOK COLLECTIVE

The Boston Women's Health Book Collective (BWHBC), authors of *Our Bodies, Ourselves For the New Century*, has worked for the past thirty years to empower all women with knowledge of their bodies, health, and sexuality.

CALIFORNIA WOMEN'S LAW CENTER

The California Women's Law Center (CWLC) is a private, nonprofit public interest law center specializing in the civil rights of women and girls. CWLC, established in 1989, works in the following priority areas: sex discrimination in education and employment, women's health and reproductive rights, family law, violence against women, and child care. Since its inception, CWLC has worked to ensure that women have full and complete access to all reproductive health services including abortion.

CENTER FOR CONSTITUTIONAL RIGHTS

The Center for Constitutional Rights (CCR) is a national, nonprofit legal, educational, and advocacy organization dedicated to advancing and protecting the rights guaranteed by the United States Constitution and the Universal Declaration of Human Rights. Founded in 1966, CCR undertakes litigation on behalf of women seeking to vindicate their civil rights, engages in advocacy on behalf of women and women's rights organizations on a wide range of issues,

and assists in the development of legislative policy at the municipal, state and federal levels of government. For more than twenty years, CCR has engaged in targeted litigation and educational outreach in an effort to maintain and bolster women's fundamental right to reproductive choice.

CENTER FOR POLICY ALTERNATIVES

The Center for Policy Alternatives (CPA) is a leading policy and research institute working with progressive leaders for positive change across the fifty states. CPA has long recognized that women's ability to make informed reproductive choices is critical to their health and economic well-being. This is especially true for women of color and low-income women, who too often bear the brunt of anti-choice restrictions. CPA supports women's reproductive choice by sharing proactive solutions and building networks of progressive leaders across the states.

CENTER FOR WOMEN POLICY STUDIES

The Center for Women Policy Studies is an independent, national, multiethnic, and multicultural feminist policy research and advocacy institution founded in 1972. The Center represents the interests of low-income women with HIV/AIDS and with substance abuse problems–who struggle to secure funds and find low-cost providers for reproductive health care and abortion services–and who will be detrimentally impacted by abortion bans such as the Nebraska statute.

CHICAGO ABORTION FUND

The Chicago Abortion Fund (CAF) fights to overturn economic barriers to reproductive choice. Through direct service and education/advocacy, CAF assists low-income women in obtaining safe abortion services by providing

clinic referrals, negotiated discounts, and financial assistance. Although unable to assist directly all the women in need, CAF works to extend choice to all low-income women by making the issue of economic access a priority on the agenda of policy makers.

CHOICE

CHOICE, founded in 1971, is a nonprofit advocacy organization dedicated to increasing access to quality medical care, to cultivating health awareness in the community, and to facilitating linkages between the public and vital social services. Nearly 36,000 consumers turn to CHOICE annually for reliable information on family planning, pregnancy options, sexually transmitted infections, and HIV/AIDS. CHOICE's highly trained staff also offer sensitive short-term counseling in crisis situations, advocate on behalf of individual consumers with providers, and educate the larger community through its community health education curriculum.

CHOICE USA

Choice USA was founded in 1992 to protect and advance reproductive freedom as a universal human right. Choice USA believes that every woman has the right to make her own decisions about contraception, abortion, and childbearing in accord with her own conscience and without government interference. Choice USA educates the public about reproductive choice issues, identifies and trains young pro-choice leaders, and supports grassroots activists in their efforts to secure reproductive freedom.

CLARA BELL DUVALL EDUCATION FUND

The Clara Bell Duvall Education Fund was created in 1979 to honor Clara Bell Duvall who died in 1929 from

complications of a self-induced abortion and left behind a widower and five young children. The Fund provides education and advocacy about the need for the full range of reproductive health options, including abortion for women of all ages, races, and income levels. The story of Clara Bell Duvall serves as a poignant reminder of the tragic consequences of illegal or inaccessible reproductive health services.

COALITION OF LABOR UNION WOMEN

The Coalition of Labor Union Women (CLUW) represents more than 25,000 working women in professions and industries throughout the United States and Canada. For more than twenty-five years, CLUW has advocated to strengthen women's ability to influence their own destinies. CLUW's Center for Education and Research engages in specific educational and advocacy programs addressing the importance of reproductive choice, particularly for women in low-wage jobs or living in poverty. CLUW has more than seventy-five chapters in cities and states around the nation and is a constituency group affiliated with the AFL-CIO.

COLORADO COALITION AGAINST DOMESTIC VIOLENCE

The Colorado Coalition Against Domestic Violence (CCADV) is a statewide, membership-driven, nonprofit organization dedicated to the elimination of domestic violence in all its forms through community education and networking. CCADV recognizes that the extent to which women can control their reproductive capacities is a principal factor in determining the quality and character of their lives; this is especially true for women in abusive relationships. CCADV has been working for over twenty years to eliminate intimate violence in women's lives in Colorado.

CONNECTICUT WOMEN'S EDUCATION AND LEGAL FUND, INC.

The Connecticut Women's Education and Legal Fund, Inc. (CWEALF) is a statewide nonprofit organization dedicated to empowering women, girls and their families to achieve equal opportunities in their personal and professional lives. CWEALF was incorporated in 1973 and has over 1,000 members.

DC COALITION AGAINST DOMESTIC VIOLENCE

The DC Coalition Against Domestic Violence (DCCADV) works to end domestic violence in the District of Columbia through direct services, advocacy, public policy, training, and community outreach and education. DCCADV recognizes that it is absolutely imperative for women in abusive relationships to have full control over their reproductive choices in order to choose a violence-free life for themselves and their children. This need is especially compelling for poor women, who are disproportionately women of color.

DOMESTIC ABUSE PROJECT OF DELAWARE COUNTY, INC.

The Domestic Abuse Project of Delaware County, Inc., is an agency that serves victims of domestic violence, many of whom are poor women and women of color. The Domestic Abuse Project recognizes that its clients would be impacted by restricting access to abortion.

ELIZABETH BLACKWELL HEALTH CENTER FOR WOMEN

The Elizabeth Blackwell Health Center for Women was founded in 1975 to provide feminist women's health services and women's health advocacy. The Center is committed to

providing high quality, accessible health services for all women in a setting that enables women to be active participants in their health care.

FAMILY PLANNING ASSOCIATION OF MAINE

Family Planning Association of Maine is a nonprofit organization that serves as the statewide Title X grantee responsible for assuring the provision of family planning services to 30,000 teens and low-income women through thirty clinical sites annually.

GEORGIANS FOR CHOICE

Georgians for Choice (GFC), a statewide pro-choice coalition, affirms that every woman must be free to make decisions about whether and when to have children. GFC supports public policies that acknowledge the moral capabilities of individuals, policies that provide accurate education about sexuality and reproduction, access to family planning services, and funding to enable all women to exercise their options. GFC opposes any public policy that creates undue hardships and bars access to reproductive health and education services. GFC believes that abortion can be a moral, ethical, and religiously responsible decision.

GREATER PHILADELPHIA WOMEN'S MEDICAL FUND

The Greater Philadelphia Women's Medical Fund (GPWMF) provides direct financial aid to help low-income women and girls in the Philadelphia metropolitan area who want to terminate a pregnancy but cannot because they do not have the money to pay for a safe, legal abortion. In 1999, GPWMF helped 830 women pay for abortions.

HAWAII STATE COALITION AGAINST DOMESTIC VIOLENCE

The Hawaii State Coalition Against Domestic Violence (HSCADV) is a private, nonprofit statewide coalition of sixteen domestic violence programs working collaboratively to affect public policy and establish a coordinated and consistent response for the safety and protection of battered women. Its goals include public recognition of domestic violence as a pervasive societal problem detrimental to all members of society and the obliteration of racism, sexism, and homophobia which contribute to domestic violence.

HAWAII WOMEN LAWYERS

Hawaii Women Lawyers (HWL) is a nonprofit organization devoted to the advancement of the civil rights and social welfare of Hawaii's citizens, particularly its women and children. HWL is a specialty bar association that operates as an independent affiliate of the Hawaii State Bar Association. Its membership consists of over 200 lawyers licensed to practice in the State of Hawaii, together with auxiliary lay and unlicensed members. Throughout its twenty-three year history, HWL has been a strong supporter of the right to choose.

ILLINOIS CAUCUS FOR ADOLESCENT HEALTH

The Illinois Caucus for Adolescent Health, a statewide membership network, provides public education, policy advocacy, training, and technical assistance on issues related to the health and well-being of adolescents, particularly teenage parents and their families. For over twenty-two years, the Caucus has recognized that in order to have choices about their future, all women must have the choice to make informed decisions about their reproduction, including the right to bring up healthy children, the right to adoption,

and the right to safe, affordable birth control and abortion services.

ILLINOIS COALITION AGAINST SEXUAL ASSAULT

The Illinois Coalition Against Sexual Assault (ICASA) is a nonprofit organization consisting of thirty-one community-based sexual assault centers in Illinois. Founded in 1977, the purpose of ICASA is to end sexual violence and to alleviate the suffering of its victims. ICASA centers counsel victims, advocate for victims in the medical and criminal justice systems, present educational programs, and provide information and referral services. One of ICASA's goals is to insure that victims of sexual violence are free to make decisions about their reproductive and mental health.

IOWA COALITION AGAINST SEXUAL ASSAULT

The Iowa Coalition Against Sexual Assault (ICASA) is a statewide coalition whose members provide a wide range of services to sexual assault survivors. ICASA envisions a world free of sexual violence in which each individual is respected and valued. Accordingly, ICASA strongly supports reproductive freedom.

LEAGUE OF WOMEN VOTERS OF THE UNITED STATES

The League of Women Voters of the United States, founded in 1920, is a nonpartisan, community-based political organization that encourages the informed and active participation of citizens in government and influences public policy through education and advocacy. The League is organized in one thousand communities and in every state, with more than 120,000 members and supporters nationwide. Since its beginning, the League has fought to ensure that women can take their full and rightful place in American

society. Based on the concurrence of its members, the League took a position in 1983 in favor of protecting the constitutional right of privacy of the individual to make reproductive choices.

LOUISIANA COALITION AGAINST DOMESTIC VIOLENCE

The Louisiana Coalition Against Domestic Violence (LCADV) is a nonprofit coalition of all domestic violence programs throughout the state of Louisiana. Incorporated since in 1982, its primary mission is to work to end violence against women and children in their homes and by intimates and acquaintances outside their homes.

MADRE

MADRE, a United States-based international women's human rights organization, has been working to defend the reproductive health and freedom of women around the world since 1983. Our 23,000 members in the United States and abroad support our understanding that any restriction on women's access to safe and legal abortion will be devastating to women's equality, health, and freedom. MADRE supports all efforts to defend reproductive health and rights as women's human rights.

MEDICAL STUDENTS FOR CHOICE

Medical Students for Choice represents over 5,000 medical students and residents who are demanding a comprehensive medical education that includes abortion training. Medical Students for Choice works on a grassroots basis at medical schools and residency programs throughout North America, sponsors national and regional educational meetings, provides reproductive health clinical training externships, maintains a presence on the Internet, and

publishes a quarterly newsletter. Medical Students for Choice is committed to ensuring that medical practitioners are prepared to provide their patients with the full range of reproductive health care choices.

MICHIGAN JOURNAL OF GENDER AND LAW

The central mission of the Michigan Journal of Gender and Law is to create a feminist legal publication that will help expand and develop legal discourse beyond traditional boundaries. The Journal is dedicated to exploring how gender issues and related issues of race, class, sexual orientation, and culture affect the lives of women and men.

MICHIGAN PRO-CHOICE NETWORK

The Michigan Pro-Choice Network is a nonprofit membership organization, consisting of twenty grassroots groups and state chapters of national organizations whose mission is to preserve the fundamental right to comprehensive reproductive health care, including safe, legal abortion.

MONTANA REPRODUCTIVE RIGHTS COALITION

The Montana Reproductive Rights Coalition was founded in 1991 to reflect a diverse statewide commitment to reproductive freedom and choice. The Coalition and individual member groups have lobbied extensively in the Montana State Legislature the past two sessions to defeat abortion bans similar to the Nebraska statute. The Montana Reproductive Rights Coalition is committed to ensuring that all women have equal and comprehensive access to reproductive health care.

MS. FOUNDATION FOR WOMEN

The Ms. Foundation for Women is the only national multi-issue women's fund. The Foundation has long recognized that the extent to which women can control their reproductive capacities is a principal factor in determining the quality and character of their lives; this is especially true for poor women and women of color, who are often the first victims of anti-choice legislation. The Ms. Foundation for Women has been responding to attacks on reproductive freedom with a combination of grantmaking, technical assistance, and advocacy for more than twenty-five years.

NATIONAL ASSOCIATION OF WOMEN LAWYERS

The National Association of Women Lawyers (NAWL), a one-hundred-year-old bar association headquartered in Chicago, was the first and is the oldest national women's bar association in the United States. NAWL's members include individuals and professional associations. NAWL is committed to ensuring that all women have safe and unobstructed access to women's health providers, including reproductive health providers.

NATIONAL BLACK WOMEN'S HEALTH PROJECT

The National Black Women's Health Project (NBWHP) is the only organization dedicated to the health and well-being of African-American women. NBWHP supports the right of all women, regardless of age, income, or education, to make decisions regarding whether, when, and under which conditions to bear children.

NATIONAL CENTER FOR LESBIAN RIGHTS

The National Center for Lesbian Rights (NCLR) is a national nonprofit legal organization dedicated to securing basic civil rights protections for lesbian women and their

families through impact litigation and public education. Since 1977, NCLR has litigated cases in more than thirty states on behalf of lesbians who have experienced discrimination in employment, housing, education, marriage, child custody, and other family law arenas. NCLR is committed to ensuring that lesbians and other women have reproductive choices and autonomy.

NATIONAL CENTER FOR THE PRO CHOICE MAJORITY

The National Center for the Pro Choice Majority is a nonprofit organization that provides a research and information service to the pro-choice movement. It publishes a national newsletter, The Pro Choice Report, about the strategies of the anti-choice movement to prevent women from exercising their constitutional right to make and carry out reproductive decisions.

NATIONAL CENTER FOR YOUTH LAW

The National Center for Youth Law (NCYL) is a nonprofit public interest law firm that has represented children, youth, and families for over twenty-five years. The health care rights of adolescents have been of special concern in our work. As counsel in *American Academy of Pediatrics vs. Lungren*, 16 Cal. 4th 307 (1997), the California Supreme Court case that struck down a state statute requiring parental consent before a minor could obtain an abortion, NCYL is acutely aware of how vulnerable young women are to statutes impeding access to abortion.

NATIONAL COUNCIL OF NEGRO WOMEN, INC.

The National Council of Negro Women, Inc. (NCNW) is a sixty-five-year-old volunteer membership organization. NCNW's purpose is to help African-American women

improve the quality of life for themselves, their families, and the community. The National Council of Negro Women has been responding to attacks on reproductive freedom with technical assistance and advocacy for a great many years.

NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION

The National Family Planning and Reproductive Health Association, an advocate for family planning and abortion providers and patients across the United States, has been dedicated to assuring universal access to voluntary, comprehensive, and culturally sensitive family planning and reproductive health care services since 1972.

NATIONAL LATINA HEALTH ORGANIZATION

The National Latina Health Organization (NLHO) works for bilingual access to quality health care through self-empowerment, educational programs, health advocacy, outreach, and developing public policy specifically aimed at Latinas. NLHO believes that women must have access to culturally respectful reproductive health care if they are to improve the quality of their lives.

NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH

The National Latina Institute for Reproductive Health (NLIRH) was founded in 1994 to empower Latinas to make informed reproductive health decisions. Latinas comprise an increasing percentage of women of reproductive age (15-49) in the continental United States, and Latinos are quickly becoming the nation's largest minority population. NLIRH's areas of programmatic focus include coalition building, education, communication, public policy, and advocacy.

NATIONAL LAWYERS GUILD

The National Lawyers Guild was founded in 1937 and seeks to unite the lawyers, law students, legal workers, and jailhouse lawyers of America into an effective political and social force in the service of the people. The Guild is committed to preserving the right of all women to choose whether and when to have children and to be guaranteed the option of obtaining safe, legal abortions.

NATIONAL NETWORK OF ABORTION FUNDS

The National Network of Abortion Funds (NNAF), created in 1993, is an association of sixty-eight community-based abortion funds in the United States. In 1999, NNAF member funds helped approximately 10,000 women who would not have been able to obtain a safe, legal abortion with their own resources by loaning or granting them a combined total of over $1.2 million.

NATIONAL ORGANIZATION FOR WOMEN FOUNDATION, INC.

The National Organization for Women Foundation (NOW Foundation) is devoted to furthering women's rights through education and litigation. NOW Foundation is affiliated with the National Organization for Women, the largest feminist organization in the United States, with a contributing membership of over 500,000 women and men in more than 450 chapters in all 50 states and the District of Columbia. Since its inception in 1986, a major goal of NOW Foundation has been to ensure reproductive freedom for women, including safe, legal, and accessible abortion and birth control.

NOW LEGAL DEFENSE AND EDUCATION FUND

NOW Legal Defense and Education Fund (NOW LDEF) is a leading national nonprofit civil rights organization that performs a broad range of legal and educational services in support of women's efforts to combat gender-based discrimination and promote equal rights. A major goal of NOW LDEF's work is to secure reproductive rights for all women. To this end, NOW LDEF has litigated numerous cases involving clinic violence and efforts to protect safe access to reproductive health services.

NATIONAL SOCIETY OF GENETIC COUNSELORS

The National Society of Genetic Counselors (NSGC) is the leading voice, authority, and advocate for the genetic counseling profession. The mission of NSGC is to promote the genetic counseling profession as a recognized and integral part of health care delivery, education, research, and public policy. The NSGC publicly supports a woman's right to reproductive freedom, including her right to prenatal diagnosis and access to safe and legal abortion.

NATIONAL WOMEN'S POLITICAL CAUCUS

The National Women's Political Caucus (NWPC) is a national, multipartisan, grassroots membership organization dedicated to supporting pro-choice women candidates for elected and appointed office. All candidates who receive NWPC's endorsement believe that a woman's reproductive health should remain unfettered by parental notification requirements and abortion procedure bans.

NATIVE AMERICAN WOMEN'S HEALTH EDUCATION RESOURCE CENTER

The Native American Women's Health Education Resource Center (NAWHERC) works to improve the lives of

Indigenous women by addressing their health, environmental, educational, and cultural rights, locally, nationally, and internationally. The traditional beliefs of Indigenous women include the belief "that the business of women is determined by women for women." Since its founding over fifteen years ago, NAWHERC has supported reproductive rights.

NORTHEAST WOMEN'S CENTER

The Northeast Women's Center has been serving the Northeast Philadelphia area for twenty-five years, providing women with safe and legal abortions. The Center provides services to women of diverse backgrounds and enables them to avoid unsafe or illegal alternatives that could endanger their lives.

NORTHWEST WOMEN'S LAW CENTER

The Northwest Women's Law Center (NWLC) is a nonprofit public interest organization that works to advance the legal rights of all women through litigation, education, legislation, and the provision of legal information and referral services. Since its founding in 1978, the NWLC has been dedicated to protecting and expanding women's reproductive rights and has long focused on the threats to women's access to abortion providers. The NWLC continues to serve as a regional expert and leading advocate on reproductive freedom.

PENNSYLVANIA COALITION AGAINST DOMESTIC VIOLENCE, INC.

The Pennsylvania Coalition Against Domestic Violence, Inc. (PCADV) is a nonprofit organization incorporated in Pennsylvania for the purpose of providing services and advocacy on behalf of victims of domestic violence and their minor children. PCADV is a membership organization of

sixty-four shelters, hotlines, counseling programs, safe home networks, legal advocacy projects, and transitional housing projects for battered women and their dependent children in the Commonwealth. For nearly twenty-five years, PCADV has provided statewide and national training and technical assistance to domestic violence programs, attorneys, the courts, and law enforcement agencies of domestic violence.

POLICY INSTITUTE OF THE NATIONAL GAY AND LESBIAN TASK FORCE

The National Gay and Lesbian Task Force (NGLTF) was founded in 1973 and is dedicated to eliminating prejudice, violence and injustice against gay, lesbian, bisexual, and transgendered people at the local, state, and federal levels. The Policy Institute of NGLTF, founded in 1995 as a program of NGLTF, is a think tank dedicated to research, policy analysis, and strategic projects to advance the greater understanding and the equality of lesbian, gay, bisexual, and transgendered people.

PROCHOICE RESOURCE CENTER

The ProChoice Resource Center is an independent, nonpartisan, nonprofit organization that provides on-site training programs, extensive technical assistance, innovative publications, and other resources to the pro-choice grassroots. PCRC also serves as a clearinghouse of information about the grassroots for the reproductive rights community, policymakers, and the media.

REPUBLICAN PRO-CHOICE COALITION

The Republican Pro-Choice Coalition is a nonprofit organization dedicated to preserving the right to reproductive choice for all women. It is developing state chapters around the country to impact legislation at the state and federal

levels that protects abortion rights and encourages family planning efforts. The Coalition strives to promote the Republican philosophy of individual liberty and limited government and maintains that those principles should apply equally to women's personal decisions with regard to reproductive health.

SEXUALITY INFORMATION AND EDUCATION COUNCIL OF THE UNITED STATES

The Sexuality Information and Education Council of the United States (SIECUS) is a thirty-five-year-old nonprofit organization, dedicated to affirming that sexuality is a natural and healthy part of life. SIECUS believes that every woman, regardless of age or income, should have the right to obtain an abortion under safe, legal, confidential, and dignified conditions.

SOUTH CAROLINA COALITION AGAINST DOMESTIC VIOLENCE AND SEXUAL ASSAULT

The South Carolina Coalition Against Domestic Violence and Sexual Assault (SCCADVASA) is a strong voice for women's rights in South Carolina. SCCADVASA has responded to attacks on reproductive freedom for many years and supports the right of women to choose.

SOUTH DAKOTA COALITION AGAINST DOMESTIC VIOLENCE AND SEXUAL ASSAULT

The South Dakota Coalition Against Domestic Violence and Sexual Assault is a coalition of programs serving victims of domestic violence and their children. It is dedicated to the proposition that domestic violence is the result of oppression in all forms and that only the obliteration of oppression will bring an end to family violence. To that end, its work

includes empowering women to take control of every aspect of their lives, including their reproductive capabilities.

THIRD WAVE FOUNDATION

The Third Wave Foundation is the only national organization for young feminist activists between the ages of fifteen and thirty. Through a national network of members (5,000 strong), public education campaigns, and grantmaking, Third Wave informs and empowers this current feminist generation.

TRADESWOMEN OF PURPOSE/ WOMEN IN NON-TRADITIONAL WORK

Tradeswomen of Purpose/Women in Non-Traditional Work, Inc. (TOP/WIN) is a nonprofit organization whose focus for over fifteen years has been to increase the number of women entering and remaining in blue-collar non-traditional jobs. Since 1989, TOP/WIN has facilitated job training programs which have prepared and placed low-income women in a variety of non-traditional occupations that offer higher wages and true economic self-sufficiency.

VOTERS FOR CHOICE

Voters For Choice is the nation's largest independent, pro-choice political action committee. Voters For Choice supports safe, legal, and accessible abortion services for all women, regardless of geographic location, age, or economic status. In order to protect the fundamental right to choose, Voters For Choice works to elect pro-choice candidates to federal and state elective office.

WASHINGTON STATE COALITION AGAINST DOMESTIC VIOLENCE

The Washington State Coalition Against Domestic Violence is a membership organization that provides training, educational resources, and advocacy on behalf of victims of domestic violence. Its mission is to end domestic violence through advocacy and action for social change.

WIDER OPPORTUNITIES FOR WOMEN

Wider Opportunities for Women (WOW) is a national nonprofit employment organization with over three decades of experience helping women and girls achieve equality of opportunity in education and employment. WOW's mission is to help low-income women and their children achieve economic self-sufficiency and to move out of poverty. WOW supports women's reproductive freedom because unwanted pregnancy and childbirth fundamentally and negatively impact women's ability to attain economic independence.

WOMEN'S ASSOCIATION FOR WOMEN'S ALTERNATIVES

Women's Association for Women's Alternatives (WAWA) is a nonprofit agency providing residential, educational, vocational, and child rearing training to girls and women. Its goal is to allow girls and mothers to keep their families together and to lead full and productive lives by giving them the skills and education they need to succeed without unnecessary or prolonged public support. As an agency, WAWA believes that it is essential to preserve and protect all the reproductive rights and options that women require to live full and complete lives free from unwarranted government intrusion.

WOMEN'S LAW CENTER OF MARYLAND

The Women's Law Center of Maryland, Inc. (WLCMD), founded in 1971, is a nonprofit, public interest, membership organization of attorneys and community members that works to establish fair treatment for women and children. WLCMD has dedicated substantial effort to reforming family law and has been recognized for its innovative direct services and effective advocacy for families via its Kaufman Center for Family Law.

WOMEN'S LAW PROJECT

The Women's Law Project (WLP) is a nonprofit, feminist advocacy organization located in Philadelphia. Founded in 1974, WLP has frequently challenged restrictive abortion statutes on behalf of women's health care providers and the women they serve. WLP served as co-counsel for plaintiffs in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), and *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986).

WOMENS WAY

WOMENS WAY is the nation's oldest and largest women's funding federation. Since its inception in 1976, WOMENS WAY has recognized that the extent to which women can control their reproductive health is a critical factor in determining the quality and impact of their lives. As attacks on reproductive choice escalate in our clinics and statehouses, WOMENS WAY continues to defend reproductive freedom by raising funds and mobilizing community resources to enhance and improve the lives of more than 260,000 Delaware Valley women and families each year.

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Supreme Court of the United States
OCTOBER TERM, 1999

DON STENBERG,
Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF OF THE NARAL FOUNDATION, THE FEMINIST MAJORITY FOUNDATION, THE NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, THE NATIONAL WOMEN'S LAW CENTER AND PEOPLE FOR THE AMERICAN WAY FOUNDATION AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF AMICI CURIAE

The NARAL Foundation, the Feminist Majority Foundation, the National Partnership for Women & Families, the National Women's Law Center, and People for the American Way Foundation are organizations committed to protecting the right of every woman to make personal decisions regarding the full range of reproductive services, including preventing unintended pregnancy, bearing healthy children, and choosing legal abortion.[1] All of the *amici* have a strong interest in the Court's decision in this case, which will have a profound effect on the right of a woman to choose, in consultation with her doctor, to terminate a pregnancy before viability in the safest manner possible. *Amici* submit this brief to help inform the Court about the obligations of state legislatures to respect a woman's right to choose an abortion unobstructed by legislation crafted for improper purposes.

Descriptions of each of the *amici* are provided in the Appendix hereto.

SUMMARY OF ARGUMENT

The Nebraska statute at issue in this case, Neb. Rev. Stat. § 28-328(1)-(4) (1999) ("the Nebraska Statute"), was enacted with the purpose of obstructing substantially a woman's right to choose an appropriate procedure for terminating a nonviable fetus. A statute with such a purpose,

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[1] This brief was not authored, in whole or in part, by any counsel for a party. No person or entity, other than the *amici curiae*, their members, or counsel contributed monetarily to the preparation or submission of this brief. The parties consented to the filing of this brief, and copies of their letters of consent have been lodged with the Clerk of the Court.

even independent of the statute's effect, is invalid under the constitutional principles set forth in *Planned Parenthood v. Casey*, 505 U.S. 833, 877 (1992). Such a statute is invalid because "the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it." *Id.*

The improper purpose of the Nebraska Statute is evident from both the language of the Statute and its legislative history, as well as the social and historical context within which it and other so-called "partial-birth" abortion legislation has emerged. Each of these types of evidence is relevant to the Court's examination of a statute's true purpose. *See Edwards v. Aguillard*, 482 U.S. 578 (1987); *Epperson v. Arkansas*, 393 U.S. 97 (1968). A plethora of such evidence demonstrates that the true purpose of the Nebraska Statute was to create an undue burden on a woman's choice to undergo a pre-viability abortion.

Contrary to Petitioners' assertions, the Nebraska Statute was not narrowly designed to prohibit a single type of abortion procedure, but rather was formulated to create a broad barrier to a woman exercising her constitutional rights. According to Petitioners, the Nebraska Statute "regulate[s] the D&X procedure and no other." Brief of Petitioners ("Pet. Br.") at 7. Both the Statute's language and its legislative history, however, belie this assertion. Had the Nebraska legislature sought to regulate only the intact dilation and extraction ("D&X") procedure, it plainly could have written such a limitation into the legislation. It did not do so. Instead, the legislature specifically rejected amendments offered for this purpose and adopted other amendments that failed either to clarify or properly circumscribe the legislation's scope.

First, the Nebraska legislature rejected an amendment to replace the term "partial-birth" abortion with the medically accurate term, "intact dilation and extraction."

(J.A. 404.) During debate on this amendment, Senator Maurstad, the bill's sponsor, admitted that replacing "partial-birth" abortion with "intact dilation and extraction" would "change what the bill is designed to do." (J.A. 381.) Second, the legislature adopted an amendment to define "partially vaginally deliver" as "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure the person performing such procedure knows will kill the unborn child and does kill the unborn child." (J.A. 424.) This language, quite contrary to Petitioners' contentions, reflects a conscious design of the Nebraska legislature to create a sphere of ambiguity with respect to the procedures to be prohibited. Indeed, several co-sponsors of the bill expressly admitted that the language is vague. Co-sponsor Senator Brashear said, "[t]here's no question there will be a fact question as to what is a substantial portion." (J.A. 444.) Likewise, co-sponsor Senator Hilgert acknowledged: "I think that everyone has an idea in their mind, that it's hard to quantify [what a 'substantial portion' is]. That's why I said it's probably a litigable issue." (J.A. 475.)

These and other comments of the sponsors of the legislation manifestly reveal that the purpose of the Nebraska Statute is to prohibit a variety of procedures as a barrier to pre-viability abortions.

The enactment of the Nebraska Statute was part of a nationwide campaign by organizations opposed to legal abortion. This campaign, led by the National Right to Life Committee ("NRLC"), is further evidence that the proponents of the Nebraska Statute, including its sponsors prior to its enactment, sought to imbue the Statute with ambiguity so that it would serve as an effective weapon against a variety of abortion procedures.

It is undisputed that one of the primary purposes of the NRLC is to end abortion – all abortion, whether pre- or post-viability. The NRLC has drafted, promoted, and vigorously lobbied for the passage of "partial-birth" abortion legislation. It has instructed legislatures in State after State on how to resist limiting or clarifying the scope of so-called "partial-birth" abortion legislation. Notably, all the States that enacted such legislation in 1996, 1997, or 1998 adopted language substantially similar to the model legislation espoused by the NRLC. Moreover, at least nine State legislatures, in addition to Nebraska's, specifically rejected attempts to narrow the definition of "partial-birth" abortion to one specific abortion procedure.

Courts that have examined so-called "partial-birth" abortion statutes have recognized that a legislature's failure to clarify the definition of "partial-birth" abortion indicates the legislature's intent to prohibit more than one procedure. For instance, the Superior Court for the Third District of Alaska concluded with respect to Alaska's "partial-birth" abortion Act:

> [T]he vagueness of the Act was brought to the attention of the legislature by a clearly worded and easily understood attorney general's opinion. Amendments were offered to correct the problem but were rejected. Having passed the Act with knowledge of the legal defects, it seems more likely than not that the unstated purpose of the Act was to cloud the scope of abortion procedures, i.e., to restrict abortion in general.

Planned Parenthood v. Alaska, No. 3AN-97-6019, 11 (Super. Ct., 3d Dist. Alaska, Mar. 13, 1998) (footnotes omitted), *appeal docketed*, No. S-08610 (Alaska Apr. 16, 1998).

The Nebraska Statute is at least as vague as the Alaska "partial-birth" statute. That vagueness does not reflect inadvertence on the part of the Nebraska legislature. The Statute is ambiguous specifically because its proponents sought to ban a wide and unspecified variety of abortion procedures and thereby obstruct substantially a woman's ability to choose the most appropriate method in her case.

Further evidence of the improper purpose of the Nebraska Statute is the fact that it and its legislative history reflect no adequate consideration for a woman's health. Under the Court's well-established jurisprudence, a State may not impose any abortion regulation that could jeopardize the life or health of a pregnant woman. *Casey*, 505 U.S. at 880 (citing *Roe v. Wade*, 410 U.S. 113, 164). Consistent with this jurisprudence and the fundamental principles underlying it, a State may not force a pregnant woman or her physician to subordinate the health of the woman to the well-being of the fetus. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768-69 (1986), *overruled in part on other grounds by Casey*, 505 U.S. 833, 870, 872-73, 882 (1992). Even after viability, when the State has the strongest interest in preserving fetal life, the State may not require a woman to sacrifice her health for the sake of the fetus. *Id.* at 879-80.

The Nebraska Statute contains no provision to protect any aspect of a woman's health. This omission was not by accident or oversight. The legislature was aware of how the Statute, even if it could be interpreted to ban only D&X, would harm women's health. The legislature heard testimony confirming such harm, yet nevertheless deliberately rejected amendments that were offered to protect women's health. For instance, it rejected an amendment that would have permitted a physician to perform an otherwise prohibited abortion procedure if other available procedures posed an equal or greater risk to the woman. (J.A. 372.) It also rejected an amendment to add an exception to preserve

the woman's fertility or her physical ability to carry future pregnancies to term. Further, it did not accept another amendment providing an exception for cases where the woman is at "serious risk of substantial impairment of a major bodily function." (JA 380, 405, 415.)

The right to choose to have an abortion includes the right to choose the safest procedure available for each individual woman. Whenever more than one abortion technique is available, a woman is entitled to have access to the safest method. *See Planned Parenthood v. Danforth*, 428 U.S. 52, 78-79 (1976). By rejecting even the very limited health exceptions proposed, the Nebraska legislature flagrantly ignored this right and the attendant requirement not to obstruct a woman's path to an appropriate abortion procedure.

The Nebraska legislature's intentional creation of a vague and overbroad abortion prohibition, together with its failure to include any exception from that prohibition to protect women's health, reveals the legislature's underlying purpose to limit a woman's choices to three unacceptable options: to undergo a riskier but legal procedure, to violate the law in order to obtain the safest procedure, or to refrain altogether from exercising the right to choose an abortion. Stated simply, the Nebraska legislature's purpose was to burden unduly a woman's right to elect an abortion. Because that purpose is plainly inconsistent with fundamental constitutional principles and the established jurisprudence of this Court, the Nebraska Statute, even independent of its unconstitutional effect, is invalid under *Casey*.

ARGUMENT

I. UNDER THIS COURT'S JURISPRUDENCE, DETERMINING THE CONSTITUTIONALITY OF A STATUTE REGULATING ABORTION PROPERLY INVOLVES CONSIDERATION OF THE STATUTE'S PURPOSES.

A. A Statute Is Invalid if Its Purpose Is to Obstruct a Woman's Right to Obtain an Abortion Prior to Viability.

This Court has held that a law restricting abortion is invalid if *either* its purpose *or* its effect is to place a "substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Planned Parenthood v. Casey*, 505 U.S. 833, 877 (1992). The Constitution forbids a State from enforcing an abortion restriction enacted with an improper purpose "because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it." *Id.*

Since deciding *Casey*, the Court has addressed the "improper purpose" prong of *Casey's* dictate in only one case: *Mazurek v. Armstrong*, 520 U.S. 968 (1997) (per curiam).[2] In *Mazurek*, the Court found that certain evidence alleged to establish the existence of an improper purpose for an abortion statute, including particular medical data and the fact that an antiabortion group drafted the legislation, did not

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[2] The lower courts have applied the "improper purpose" prong of *Casey* in a variety of cases. *See, e.g., Jane L. v. Bangerter*, 102 F.3d 1112 (10th Cir. 1996) (finding a statute regulating abortions after the gestational period of twenty weeks to be unconstitutional because it was enacted for the improper purpose of obstructing women's choice to abort a nonviable fetus after that period), *cert. denied*, 520 U.S. 1274 (1997).

suffice to support the imposition of a preliminary injunction on the statute's enforcement. *Id.* at 973-74. The Court stated: "One searches the Court of Appeals' opinion in vain for any mention of any evidence suggesting an unlawful motive on the part of the Montana legislature." *Id.* at 972.[3]

There is no similar lack of evidence in this case. As discussed in detail *infra*, a plethora of evidence reveals that the Nebraska legislature intended the statute at issue here, Neb. Rev. Stat. § 28-328(1)-(4) ("the Nebraska Statute"), to place a substantial obstacle in the path of a woman seeking an abortion prior to fetal viability. That body of evidence is more than sufficient to support the judgment below that the Nebraska Statute imposes an undue burden on a woman's right to an abortion and therefore is invalid under *Casey*.

B. A Full Review of a Statute's Legislative History Is Required to Determine Whether an Unconstitutional Motive Led to the Statute's Enactment.

When examining the purpose of a statute, the Court looks to the statute's language, its legislative history, the social and historical context of the statute and other legislation concerning the same subject matter. The inquiry

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[3] Following *Mazurek*, in *Okpalobi v. Foster*, 190 F.3d 337 (5th Cir. 1999*), reh'g en banc granted,* 201 F.3d 353 (2000), the Fifth Circuit struck down a Louisiana law creating tort liability for abortion providers as unconstitutionally placing an undue burden on a woman's right to an abortion. In *Okpalobi*, the court considered several factors in determining that the statute was enacted for an improper purpose, including: (1) the language of the challenged act; (2) the act's legislative history; (3) the social and historical context of the legislation; and (4) other legislation concerning the same subject matter as the challenged act. 190 F.3d at 354, *citing Shaw v. Hunt*, 517 U.S. 899 (1996).

must be exacting to ensure that a facially inoffensive statute enacted for an improper purpose does not escape constitutional scrutiny. As the Court emphasized in *Edwards v. Aguillard*, 482 U.S. 578 (1987): "While the Court is normally deferential to a State's articulation of a [purportedly legitimate] purpose, it is required that the statement of such purpose be sincere and not a sham." *Id.* at 586.

In evaluating the legislature's purpose in *Edwards*, which involved a Louisiana statute requiring that "creation-science" be taught in public schools if evolution was taught, the Court reviewed the full record of the statute's legislative history, including the statements of the statute's principal sponsor, to ascertain the sincerity of the legislature's stated goals. The Court observed:

> It is clear from the legislative history that the purpose of the legislative sponsor, Senator Bill Keith, was to narrow the science curriculum. During the legislative hearings, Senator Keith stated: "My preference would be that neither [creationism nor evolution] be taught."

Id. Despite the legislature's stated purpose of providing academic freedom, the Court recognized that it "need not be blind in this case to the legislature's preeminent religious purpose in enacting this statute." *Id.* at 590; *see also Stone v. Graham*, 449 U.S. 39 (1980) (finding that an avowed secular purpose does not demonstrate a statute's constitutionality where the preeminent purpose of the statute was plainly religious).

In addition to legislative history, the social and historical context of a statute is also an important factor that the Court may consider in determining whether the statute was enacted for an improper purpose. In both *Edwards* and

Epperson v. Arkansas, 393 U.S. 97 (1968), the Court noted that the challenged statutes were "'a product of the upsurge of "fundamentalist" religious fervor' that has long viewed this particular scientific theory as contradicting the literal interpretation of the Bible." *Edwards*, 482 U.S. at 590 (quoting *Epperson*, 393 U.S. at 98). In *Epperson*, after reviewing the history of the anti-evolution statutes, the Court concluded that there was no doubt that the Arkansas legislature had a religious motive in enacting that State's anti-evolution statute, as did the legislatures of other States with similar statutes. *Epperson*, 393 U.S. at 109.

Likewise, in numerous other contexts in which statutes have been challenged as unconstitutional, the Court has examined the legislative history, the historical background, and the specific events leading to the statute's enactment, including the statements of both the legislators involved and others who encouraged the enactments. *See, e.g., Church of the Lukumi Babablu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 540 (1993) (holding that evidence relevant to discerning an unlawful discriminatory purpose includes, among other things, the historical background of the decision under challenge, the specific series of events leading to the enactment or official policy in question and the legislative or administrative history, including contemporaneous statements made by members of the decisionmaking body); *see also Hunt v. Cromartie*, 526 U.S. 541, 599-50 (1999) (in determining that there were triable issues regarding whether the State legislature's congressional redistricting plan was racially motivated, the Court considered, *inter alia*, expert affidavit testimony alleging that the State ignored traditional districting criteria and statistical and demographic evidence regarding the precincts included within the district and those excluded); *Grosjean v. American Press Co.*, 297 U.S. 233, 250 (1936) (condemning a tax statute "because, in the light of its history and of its present setting, it is seen to be a deliberate and calculated

device in the guise of a tax to limit the circulation of information.").

In this case, not only the text of the Nebraska Statute and its legislative history, but also the social and historical context from which it emerged, all demonstrate that it was enacted for the improper purpose of obstructing a woman's choice to terminate a pregnancy prior to fetal viability. The existence of this purpose alone, even disregarding the fact that the Statute also has the *effect* of obstructing such a choice, renders the Statute invalid under the established abortion jurisprudence of this Court.

II. THE HISTORY AND SURROUNDING CONTEXT OF THE NEBRASKA STATUTE REVEAL THAT IT WAS ENACTED FOR THE IMPROPER PURPOSE OF OBSTRUCTING A WOMAN'S RIGHT TO SAFE ABORTION PROCEDURES.

A. The Legislative History of the Nebraska Statute Demonstrates That the Statute Was Enacted to Create a Substantial Obstacle to Women Seeking Abortion Not Merely by Banning One Medically Safe Procedure.

Petitioners vigorously assert that the Nebraska Statute "regulate[s] the D&X procedure and no other." Brief of Petitioners ("Pet. Br.") at 7. This assertion cannot be reconciled with either the Statute's language or its legislative history. In Nebraska, as in other States across the country, the legislature specifically rejected attempts to limit the legislation to a single procedure. Had the Nebraska legislature sought to regulate only the intact dilation and extraction ("D&X") procedure, it plainly could have written

such a limitation into the legislation.[4] By deliberately eschewing this option, the legislature demonstrated a broader intent to ban a variety of abortion procedures and thereby reinforce exponentially the intended barrier to a woman's ability to exercise her right to choose a safe abortion.

1. The Nebraska Legislature Explicitly Rejected Replacing the Rhetorical Term "Partial-Birth" Abortion with the Medical Term "Intact Dilation and Extraction."

On May 14, 1997, the Nebraska legislature rejected an amendment to replace the term "partial-birth" abortion with the medically accurate term, "intact dilation and extraction."[5] (J.A. 404.) During debate on this amendment,

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[4] Even if the legislature had, in fact, banned the D&X procedure alone, the resulting law would not have been constitutional: banning a medically safe abortion procedure does not comport with constitutional dictates. *See Planned Parenthood v. Danforth*, 428 U.S. 52, 78-79 (1975).

[5] Throughout their brief, Petitioners attempt to portray the vague language of the Nebraska Statute as clear by using the term "partial-birth abortion/D&X." "D&X," however, was not used in the Statute and was specifically rejected by the Nebraska legislature. Petitioners also assert that the "partial-birth" abortion technique is "now medically known as D&X," implying that at the time the legislature rejected the term "D&X" and passed the statute without reference to D&X, the term was unknown. The record proves the contrary: Senator Maurstad, the principal sponsor of the Nebraska Legislation, had read and even quoted portions of a well-known 1992 medical presentation on D&X. *See* Martin Haskell, "Dilation and Extraction for Late Second Trimester Abortion" *in Second Trimester Abortion: From Every Angle, Fall Risk Management Seminar* (National Abortion Federation, Sept. 13-14, 1992) (cited in 142 Cong. Rec.

(footnote continued on next page)

Senator Maurstad, the bill's sponsor, admitted that replacing "partial-birth" abortion with "intact dilation and extraction" would "change what the bill is designed to do." (J.A. 381.) At one point, Senator Maurstad described "partial-birth abortion" as a procedure in which "a child is partially delivered. Every part of the child is outside the womb of the mother except for its head." (J.A. 366.) Yet he refused to add language to the bill to reflect this description, explaining that "partially delivered" could mean that as little as "a foot" is past the woman's cervix. (J.A. 367.) While averring that his previous description of the procedure was "an accurate example of the definition provided in the bill," he conceded that was "*not the only example*." (J.A. 383.) (Emphasis added.)

Had the Nebraska legislature sought to ban the D&X procedure alone, it would not have rejected the language offered for this stated purpose, and certainly not on the ground that the proposed language would conflict with the bill's design. By rejecting the proffered language, the legislature made clear that its intent was not narrowly focused, but rather was to obstruct broadly and substantially women's access to safe abortion procedures.

2. The Legislature Knew That the Legislation Was Vague and Would Ban Abortion Procedures Other Than D&X.

On May 20, 1997, the Nebraska legislature adopted an amendment to define "partially vaginally deliver" as "deliberately and intentionally delivering into the vagina a

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H2913-H2914 (daily ed. Mar. 27, 1996)); *see also* J.A. 713-14 (memorandum from Senator Maurstad to co-sponsors of LB 23 (Apr. 1997), quoting Haskell).

living unborn child, or a substantial portion thereof, for the purpose of performing a procedure the person performing such procedure knows will kill the unborn child and does kill the unborn child."[6] (J.A. 424.) Petitioners argue that this language was added to clarify the scope of the legislation and to exclude from its prohibition the dilation and evacuation ("D&E") procedure, one of the most common second trimester abortion procedures. Pet. Br. at 22. This contention, however, is at odds with the record, which indicates that the legislature knew that the legislation was vague and would ban a variety of abortion procedures.

For example, when asked whether the definition could include a procedure in which the fetus was not in a breech position, Senator Maurstad admitted that the language could include D&E. "That certainly could be the case and it could, at that point, delivery stopped [sic] and either the child dismembered or the child be killed in the manner that I spoke of earlier." (J.A. 443.) In addition, when asked to define "substantial portion," Senator Maurstad answered that it meant "a great deal of," "a lot of," or "more than a little bit has been delivered into the vagina." (J.A. 429, 430, 442.) When asked whether two people might interpret the phrase differently, he conceded: "Yes, substantial would be subjective." (J.A. 431.)

Several co-sponsors of the bill also agreed that the definition of the procedure was vague. Co-sponsor Senator Brashear said: "There's no question there will be a fact question as to what is a substantial portion." (J.A. 444.) Echoing this sentiment, co-sponsor Senator Hilgert acknowledged: "I think that everyone has an idea in their mind, that it's hard to quantify [what a 'substantial portion' is]. That's why I said it's probably a litigable issue." (J.A. 475.) Senator Hilgert also said that the descriptions and illustrations of the procedure offered during committee hearings were not exclusive of what would be covered by the legislation. "This bill does encompass more than [the] specific examples that people related and the illustrations presented [at the hearings]." (J.A. 478, 479.) When asked whether a physician reading the phrase "substantial portion" would know what is prohibited, co-sponsor Senator Bromm answered, "I think it would be difficult . . . I think their inclination would be simply not to take the risk." (J.A. 456.)

[6] This definition tracks an amendment that the U.S. Senate had adopted the same day. 143 Cong. Rec. S4694 (1997).

The comments of these legislators – the principal sponsor and the co-sponsors of the legislation – reveal that the purpose of the Nebraska Statute is not to ban one abortion procedure, as Petitioners now assert, but rather to prohibit a variety of procedures, chill medical practice, and threaten physicians with lengthy prison terms and litigation over interpretive questions.

B. Legislative History from Other States Corroborates That the Purpose of the Legislation Was to Prohibit a Variety of Abortion Procedures.

Nebraska's decision to enact a ban on so-called "partial-birth" abortion was part of a nationwide campaign by organizations opposed to legal abortion.[7] The ban was

[7] One anti-abortion strategist advised activists that "[I]t would be imprudent to confront the Court with a general prohibition on abortion. A wiser strategy is to match the natural rhythms of the reversal process by confronting the Court with a series of specific, carefully considered issues calculated to open life-sapping wounds in the *Roe* doctrine." Victor G. Rosenblum & Thomas J. Marzen, "Strategies for Reversing Roe v. Wade through the Courts," *in Abortion and the Constitution: Reversing Roe v. Wade through the Courts*, 193, 199 (Dennis J. Horan, et al eds., 1987).

contrived following a 1992 National Abortion Federation Risk Management Seminar where a well-respected physician and abortion provider, Dr. Martin Haskell, gave a presentation on the D&X technique he had developed. Anti-choice activists obtained his monograph and the National Right to Life Committee ("NRLC") first used it to galvanize opposition to the then-pending federal Freedom of Choice Act.[8]

In 1996, the NRLC sent a memorandum to State advocates with model language for so-called "partial-birth" abortion bills.[9] The memorandum indicates that the definition of "partial-birth" abortion is "crucial" and "should be retained in any legislation dealing with partial birth abortion that is introduced in any state legislature." Under the heading "Dangers of Changing the Definition of Partial-Birth Abortion," this NRLC memorandum strongly warns against any changes in the name of the banned procedure or in the definition of that procedure. It advises:

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[8] Diane M. Gianelli, *Shock-Tactic Ads Target Late-Term Abortion Procedure*, Am. Med. News, July 5, 1993, at 3.

[9] Memorandum from Douglas Johnson, NRLC Federal Legis. Dir., and Mary Spaulding Balch, NRLC State Legis. Dir., to NRLC State Affiliates and Other Interested Parties (Nov. 22, 1996). This memorandum also went to state legislators to use to draft the legislation. *See* Letter from David S. Niss, Staff Attorney, Montana Legis. Servs. Div. to Montana State Rep. Dan McGee (Dec. 18, 1996) ("Because the material I was provided from the National Right to Life Committee, Inc. on this subject purported to apply the definition of a "partial-birth" abortion to an abortion at any stage of development of the fetus without regard to its viability, I have drafted the legislation in the same manner, assuming it was your intent to prohibit partial-birth abortion at any stage of a pregnancy . . . . Because the enclosed legislation is not likewise . . . limited, it's my belief that the bill, as drafted, is unconstitutional.").

> When someone attacks the definition as "unclear" or as overly sweeping, simply keep reading the definition and asking, "What part of this is not clear? Please describe in detail the procedures that you want to do that you believe would be banned by this definition." Generally, the pro-abortion side quickly drops this discussion, as it serves mainly to focus the discussion on the grisly mechanics of late-term abortions.

Plainly, the primary proponents of so-called "partial-birth" abortion legislation knew that the scope of the legislation was not, in fact, limited to a specific technique. And the NRLC knew this well in advance of court decisions finding the language of the bills overly broad and vague.[10]

It is undisputed that one of the primary purposes of the NRLC is to end abortion – all abortion, whether pre- or post-viability. The NRLC drafted, promoted, and vigorously lobbied for the passage of the "partial-birth" abortion legislation. The NRLC's prominent role in the legislative process is significant. As Justice Powell noted in his concurring opinion in *Edwards,* although the Louisiana statute at issue in that case itself did not express a religious purpose, statements of the organizations supporting the legislation made clear that the statute had such a purpose. *Edwards*, 482 U.S. at 601-02 ("Information on . . . these organizations is part of the legislative history, and a review of their goals and activities sheds light on the nature of

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[10] The first court case reviewing a so-called "partial-birth" abortion statute was *Evans v. Kelly*, 977 F. Supp. 1283 (E.D. Mich. 1997). The temporary restraining order in *Evans* was issued on April 23, 1997, five months after the NRLC memorandum was written.

creation science as it was presented to, and understood by, the Louisiana Legislature."). Similarly, in *McLean v. Arkansas Bd. of Educ.*, where the district court evaluated legislation nearly identical to the statute at issue in *Edwards*, the court found evidence of legislative purpose in the overt religious purpose of the private sector drafter of the legislation, which was adopted nearly wholesale by the Arkansas legislature. *See McLean*, 529 F. Supp. at 1261-63. As in *Edwards*, the religious purpose of the drafter was relevant in *McLean* because, in adopting the model legislation, Arkansas took no steps to mitigate the legislation's improper religious implications. *Cf. Planned Parenthood v. Atchison*, 126 F.3d 1042, 1049 (8th Cir. 1997) (state authorities' response to efforts of anti-abortion group, among other factors, easily supported district court finding that intent of state authorities was to impede or prevent access to abortion and therefore constituted an undue burden; "the groups opposed to abortion have a perfect right to lobby . . . . Our concern, however, chiefly lies in the state authorities' response to these lobbying efforts.").

The NRLC instructed legislatures in State after State on how to resist limiting or clarifying the scope of so-called "partial-birth" abortion legislation. Notably, all the States that enacted such legislation in 1996, 1997, or 1998 adopted language substantially similar to the model legislation espoused by the NRLC. Moreover, at least nine State legislatures, in addition to Nebraska's, specifically rejected attempts to narrow the definition of "partial-birth" abortion to one specific abortion procedure.[11] For example, four State

[11] The nine States in addition to Nebraska (J.A. 380) are: Alaska, Indiana, Iowa, Kansas, Michigan, Missouri, Tennessee, Virginia, and Wisconsin. *See* Alaska Senate Journal, Apr. 9, 1997; Indiana Senate Bill 61 (1997) (Senate Motion SB61-4 (failed Feb. 4, 1997)); Iowa Senate Journal, Feb. 5, 1998 at 211; Kansas Senate Journal, Apr. 10, 1997 at 792-94; Kentucky House

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legislatures – Iowa, Missouri, Virginia and Wisconsin – rejected amendments that would have used the medical definition of D&X outlined by the American College of Obstetrics and Gynecologists ("ACOG").[12]

Even when asked to exclude certain abortion procedures – abortion procedures clearly different from the rhetoric used to describe the "partial-birth" abortion legislation – legislatures refused. In Tennessee, the legislature rejected an amendment that explicitly stated that the legislation does not include D&E abortion. Tennessee House Journal, May 27, 1997, at 1705-07. Likewise, the Iowa legislature rejected an amendment to exclude the most common first and second trimester abortion procedures: "vacuum aspiration, suction aspiration, dilation and curettage, suction curettage, induction, [and] dilation and evacuation procedures." Iowa Senate Journal, Feb. 5, 1998,

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Amendment 14, Doc. ID 983612 (defeated Mar. 19, 1998); NARAL/NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights* 80 (1997 NARAL/NARAL Foundation), (Michigan HB 5889 (1996)); Missouri Senate Journal, Apr. 29, 1999; Tennessee House Journal, May 27, 1997 at 1707; Wisconsin Assembly Journal, May 20, 1997 at 164, 165; Wisconsin Senate Journal, Mar. 26, 1998 at 563 (amendment laid on table).

[12] A widely used and quoted ACOG statement on D&X notes that the descriptions in the legislation are "vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques." The ACOG statement defines D&X as including the following elements: (1) deliberate dilatation of the cervix; (2) instrumental conversion of the fetus to a footling breech; (3) breech extraction of the body excepting the head; and (4) partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus. *See* J.A. 599-600.

at 211. The Iowa legislature went even farther when it rejected an amendment providing:

> It is the intent of the general assembly that the provisions of this Act shall only apply to one singular procedure. It is also the intent of the general assembly that this Act comply with the constitutional limitations imposed on the states by the United States Supreme Court precedents which are in effect on the effective date of this Act.[13]

By refusing to eliminate even first trimester abortion procedures from the scope of their "partial-birth" abortion prohibitions, these legislatures demonstrated that their true purpose was to ban a variety of abortion procedures.[14]

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[13] Iowa House Journal, Feb. 18, 1998 at 286. Similarly, the sponsors of the federal legislation indicated that that legislation was not limited to one procedure. For example, in a "Dear Colleague" letter urging support for the House version of the legislation, its sponsor, Representative Charles Canady, expressly explained that "[t]he ban would have the effect of prohibiting *any abortion* in which a child was partially delivered and then killed – no matter what the abortionist decides to call his particular technique." Letter from Rep. Charles T. Canady to Members of Congress, at 1 (Mar. 18, 1996).

[14] The Nebraska legislature, like these other legislatures, omitted from its "partial birth" abortion legislation any reference to a specific gestational age. By its terms, the Nebraska Statute applies to abortion procedures at any stage of pregnancy, including first-trimester abortions. The fact that Statute is not targeted at post-viability procedures reflects an apparent strategy designed by anti-abortion groups for advancing provocative abortion legislation: "the main intention is the passage of legislation offering an opportunity for a willing Supreme Court to begin the [*Roe*] reversal process by discarding 'viability' as a valid criterion for

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Courts that have examined so-called "partial-birth" abortion statutes have recognized that a legislature's failure to clarify the meaning of "partial-birth" abortion indicates the legislature's intent to prohibit more than one procedure. For instance, the Superior Court for the Third District of Alaska concluded with respect to Alaska's "partial-birth" abortion act:

> [T]he vagueness of the Act was brought to the attention of the legislature by a clearly worded and easily understood attorney general's opinion. Amendments were offered to correct the problem but were rejected. Having passed the Act with knowledge of the legal defects, it seems more likely than not that the unstated purpose of the Act was to cloud the scope of abortion procedures, i.e., to restrict abortion in general.

Planned Parenthood v. Alaska, No. 3AN-97-6019, 11 (Super. Ct., 3rd Dist. Alaska, Mar. 13, 1998) (footnotes omitted), *appeal docketed*, No. S-08610 (Alaska Apr. 16, 1998). *See also Planned Parenthood v. Miller*, 30 F. Supp. 2d 1157, 1165 (S.D. Iowa 1998), *aff'd*, 195 F.3d 386 (8th Cir. 1999), *pet. for cert. filed*, No. 99-1112 (U.S. Dec. 23, 1999); *Causeway Med. Suite v. Foster*, 43 F. Supp. 2d 604, 619 (E.D. La. 1999) ("Defendants' claim that this law applies only to the D&X procedure is not particularly credible. Were that the case, the legislature could have done

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the onset of a compelling state interest in protecting life." Victor G. Rosenblum & Thomas J. Marzen, "Strategies for Reversing Roe v. Wade through the Courts," *in Abortion and the Constitution: Reversing Roe v. Wade through the Courts*, 193, 199 (Dennis J. Horan, et al eds., 1987).

a number of things to ensure that application."), *appeal filed*, No. 99-30324 (5th Cir. Apr. 5, 1999); *A Choice for Women v. Butterworth*, 54 F. Supp. 2d 1148, 1155 (S.D. Fla. 1998) ("If the Florida legislature had intended to prohibit only the intact D&X procedure they could have easily done so by incorporating the language set forth in the ACOG statement of policy."), *appeal dismissed*, No. 99-4002 (11th Cir. Mar. 2, 1999); *Rhode Island Med. Soc. v. Whitehouse*, 66 F. Supp. 2d 288, 305 (D.R.I. 1999), *appeal filed*, Nos. 99-2141 (1st Cir. Sept. 20, 1999 and Oct. 5, 1999); *Planned Parenthood v. Verniero*, 41 F. Supp. 2d 478, 496 (D.N.J. 1998), *appeal filed*, No. 99-5042 (3d Cir. Jan. 6, 1999); *Eubanks v. Stengel*, 28 F. Supp. 2d 1024, 1035-38 (W.D. Ky. 1998), *appeal filed*, No. 98-6671 (6th Cir. Dec. 4, 1998). In *Hope Clinic v. Ryan*, 195 F.3d 857, 863 (7th Cir. 1999), the Seventh Circuit suggested that the rejection by the Wisconsin State legislature of the ACOG definition of the D&X procedure was understandable since any small variation in the procedure would render the abortion outside the scope of the challenged statute's prohibition. The fact that the legislature considered the ACOG definition as a clarification of the bill's scope, however, demonstrates that the legislature was aware of significant concerns about the legislation's vague and overbroad scope.

III. THE LEGISLATURE'S FAILURE TO GIVE ADEQUATE WEIGHT TO WOMEN'S HEALTH ALSO REVEALS THAT THE NEBRASKA STATUTE WAS INTENDED TO OBSTRUCT SUBSTANTIALLY A WOMAN'S ACCESS TO AN ABORTION.

The Nebraska legislature's intentional failure to give adequate weight to women's health in its "partial-birth" abortion prohibition is further evidence of the illegitimate purpose of the Nebraska Statute. This Court's well-established jurisprudence recognizes that a State may not impose any abortion regulation that could jeopardize the

life or health of a pregnant woman. As the Court affirmed in *Casey*, "the essential holding of *Roe* forbids a State to interfere with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." *Casey*, 505 U.S. at 880 (*citing Roe v. Wade*, 410 U.S. 113, 164 (1973)); *see also Harris v. McRae*, 448 U.S. 297, 316 (1980) ("[I]t could be argued that the freedom of a woman to decide whether to terminate her pregnancy for health reasons does in fact lie at the core of the constitutional liberty identified in [*Roe*]."). A legislature's invalid purpose to obstruct the path to an abortion is evident wherever the legislature disregards women's health.[15]

Consistent with the fundamental principle that a woman's health must be protected, the Court's jurisprudence prohibits a State from forcing a pregnant woman or her physician to subordinate the health of the woman to the well-being of the fetus. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768-69 (1986), *overruled in part on other grounds by Casey*,

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[15] The Court's jurisprudence obligating legislatures to treat women's health as paramount when enacting laws to restrict abortion reflects the Court's recognition of the devastating effects that restrictions on abortion had on women's health prior to *Roe*. In 1965, illegal abortion accounted for an estimated 17 percent of all deaths due to pregnancy and childbirth. *See Vital Statistics of the United States, 1965: Vol. II Mortality*, Part A (U.S. Gov't Printing Office). One report published in 1968 estimated that "as many as 5,000 American women die each year as a direct result of criminal abortion. The figure of 5,000 may be a minimum estimate, inasmuch as many such deaths are mislabeled or unreported." Richard H. Schwarz, *Septic Abortion* 7 (1968). Today, the mortality rate from abortion at all stages of gestation is 0.6 per 100,000 procedures. *See* Maureen Paul et al., *A Clinician's Guide to Medical and Surgical Abortion* 19 (1999).

505 U.S. 833, 870, 872-73, 882 (1992); *Colautti v. Franklin*, 439 U.S. 379, 400 (1979) (finding a statute invalid where "it is uncertain whether the statute permits the physician to consider his duty to the patient to be paramount to his duty to the fetus, or whether it requires the physician to make a 'trade-off' between the patient's health and increased chances of fetal survival"). Even after viability, when the State has the strongest interest in preserving fetal life, the State may not require a woman to sacrifice her health for the sake of the fetus. *Casey*, 505 U.S. at 879-80.

Both the plain language and the legislative history of the Nebraska Statute demonstrate that, in enacting this so-called "partial-birth" abortion legislation, the Nebraska legislature intentionally disregarded the legislation's adverse health ramifications for women.

A. The Nebraska Legislature Specifically Rejected Provisions to Protect Women's Health.

The Nebraska Statute contains no provision to protect any aspect of a woman's health. The Statute includes only a narrow exception to permit an abortion that is absolutely "necessary" to preserve the *life* of a woman "endangered by a physical disorder, physical illness, or physical injury," Neb. Rev. Stat. § 28-328(1). Thus, the Statute fails to protect a woman's health in any case where death is not probable and imminent.

It was not by accident or oversight that the Nebraska legislature omitted the required protections for women's health. The legislature was aware of how the Statute, even if it could be interpreted to ban only D&X, would harm women's health. The legislature heard testimony, for example, from Vikki Stella, a diabetic who had undergone an abortion using the D&X procedure, regarding the health implications of banning the procedure. Ms. Stella had

terminated her wanted pregnancy because the fetus suffered from "at least nine major anomalies," the most serious of which was a fluid-filled cranium with no brain tissue. Transcript of Hearing before Nebraska Committee on Judiciary 55-56 (Feb. 12, 1997). She explained:

> We were faced with the most difficult and painful decision of our lives. The only thing keeping [my son] Anthony alive was my body .... I made the agonizing decision to take my son off life support. As an insulin dependent diabetic, I don't heal as well as other people and infections can be deadly. Waiting for normal labor to occur or inducing labor early, or a C-section would have put my life and my health at risk.... But this procedure [D&X] was important to me not only because of my tenuous health but because we wanted another child. And as promised, the surgery preserved my fertility.... This procedure was not a matter of convenience. It was a medical necessity.

Id. at 56.

Despite this clear warning, the legislature deliberately rejected amendments that were offered to protect women's health. For instance, it rejected an amendment that would have permitted a physician to perform an otherwise prohibited abortion procedure if other available procedures posed an equal or greater risk to the woman. (J.A. 372.) The proposed amendment would have substituted a clause in the original version of the legislation stating "and no other medical procedure would suffice for [the] purpose [of

preserving a woman's life]" with the clause "any procedure would pose equal or greater medical risk."[16]

The legislature also rejected an amendment to add an exception to preserve the woman's fertility or her physical ability to carry future pregnancies to term, and did not accept another amendment providing an exception for cases where the woman is at "serious risk of substantial impairment of a major bodily function." (JA 380, 405, 415.) In opposing the latter amendment, Senator Maurstad, the bill's sponsor, stated without further elaboration that "partial-birth" abortion is "not medically necessary."[17] (JA 414.)

While a particular abortion procedure may not be the only procedure available for preserving a woman's life or health, it may be the best or more appropriate procedure in a specific circumstance. (J.A. 600-01.) The right to choose to have an abortion includes the right to choose the safest procedure available for each individual woman. Whenever more than one abortion technique is available, a woman is entitled to have access to the safest method. *See Planned Parenthood v. Danforth*, 428 U.S. 52, 78-79 (1976).[18] By rejecting even the very limited health exceptions proposed,

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[16] The life exception eventually codified in the Statute is restricted to procedures "necessary" to preserve the woman's life, which has the same effect as the clause "no other medical procedure would suffice for that purpose." Neb. Rev. Stat. § 28-328(1)-(4).

[17] This latter amendment was withdrawn after Senator Maurstad conferred with its sponsor. (J.A. 415.)

[18] In *Danforth*, the Court invalidated a ban on the use of the saline amniocentesis abortion method in part because the ban "forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." *Danforth*, 428 U.S. at 78-79.

the Nebraska legislature flagrantly and deliberately ignored this right and the attendant requirement not to obstruct a woman's right to choose an appropriate abortion procedure for health reasons.

The Nebraska legislature's failure to tailor the Nebraska Statute to protect women's health was a part and product of a national campaign aimed at obstructing women's access to abortions at any cost. That campaign, waged in the halls of Congress and in State legislatures throughout the country, is relevant evidence that the Nebraska Statute was enacted with the impermissible intent to subordinate women's health to political expressions condemning and sensationalizing abortion procedures.

B. The Nebraska Legislature, Members of Congress, and Other Proponents of So-Called "Partial-Birth" Abortion Statutes Have Ignored the Facts About Women's Health.

As noted above, the Nebraska Legislature was specifically informed about the adverse health implications of the Nebraska Statute prior to its enactment. The legislature's deliberate rejection of provisions to prevent the Statute from endangering women's health mirrors a pattern followed by anti-abortion advocates in Congress and in other State legislatures. At least ten times, proponents of the federal "partial-birth" abortion legislation succeeded in thwarting attempts to include in the legislation an exception to protect women's health.[19] As one of the principal

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[19] The House passed two rules prohibiting health exception amendments from being considered. *See* 141 Cong. Rec. H11602 (1995); 142 Cong. Rec. H2904, H2905 (1996). The Senate defeated one health exception amendment and two amendments providing for such an exception and limiting the ban to post-

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sponsors of the legislation made clear, in the proponents' view, a women's health is *never* an appropriate reason for an abortion, irrespective of the procedure: "a life for a life is certainly an even trade . . . . But when something less than a life is at risk, then I don't think the trade is equal." 141 Cong. Rec. S16761-03, S16764 (1995) (statement of Rep. Hyde).

This position cannot be reconciled with this Court's determination that restrictions on abortion procedures must not pose a threat to women's life *or* health. It also is painfully blind to the experiences of women whose health (either physical or mental) critically depended on the right to terminate a pregnancy. Compelling statements of women who have testified about their medically necessary abortions dramatically illustrate why restrictions such as those imposed by the Nebraska Statute impermissibly burden women's choice, even if those restrictions could somehow be interpreted to ban only D&X. The following two descriptions, among more than ten in the public record, are exemplary:

- Coreen Costello, a conservative Christian, testified that during the seventh month of her third pregnancy she began having premature contractions. Her doctors determined that her baby was suffering from a lethal neurological disorder and was unable to absorb the amniotic fluid. Because of their profound

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viability abortions. 141 Cong. Rec. S18198 (1995); 143 Cong. Rec. S4537, S4575 (1997). The House Judiciary Committee did the same. H. Rep. 105-24 (1997) at 21, 22. The House tabled a motion to recommit H.R. 1122 to committee with an amendment to add a health exception and limit the ban to post-viability abortions, and defeated a motion to recommit the bill with a health exception amendment. 143 Cong. Rec. H1228, H1230 (1997).

religious beliefs, the Costellos wanted to deliver their baby naturally. During the more than two weeks waiting for a natural birth, Coreen's health worsened as the amniotic fluid continued to accumulate in her uterus, a medical condition called polyhydramnios. The medical experts treating Coreen determined that the baby's head was too large to fit through Coreen's cervix. After much anguish, Coreen's physician recommended that she have a D&X abortion as the most appropriate option for her. Coreen concluded her testimony, "Because of the safety of this procedure, I am now pregnant again and will have another baby in June. Thanks to the grace of God and the skill and compassion of Dr. McMahon, I can have another healthy baby. If you outlaw this surgical procedure, other women like me will be denied that gift, that joy. They may lose their ability to have more children; they may lose their health; they may lose their lives." *Partial-Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the House Judiciary Subcommittee on the Constitution* (1996).

- Viki Wilson, a registered nurse, who in the 36th week of her third pregnancy discovered that her baby was suffering from an encephalocoele in which two-thirds of the baby's brain was on the outside of her skull. Because of the size of the encephalocoele, Viki's doctors were concerned that her uterus would rupture if she gave birth naturally, rendering her sterile. Her doctors did not recommend a cesarean section because the risk of the surgery could not be justified since there was no chance of saving the baby. She urged, "There will be families in the future faced with this tragedy because pre-natal testing is not infallible. I urge you, please don't take away the safest procedure available." *Partial-Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the*

Senate Comm. on the Judiciary, 104th Cong., 1st Sess. 281-82 (1995).

Legislatures throughout the country, including Nebraska's, summarily dismissed the record of these and other women's similar experiences.

CONCLUSION

The Nebraska legislature deliberately designed its so-called "partial-birth" abortion legislation to limit a woman's choice to one of three unacceptable options: to undergo a riskier but legal procedure, to violate the law in order to obtain the safest procedure, or to refrain altogether from exercising the right to choose a safe abortion. By intentionally crafting the Nebraska Statute so as to restrict a woman's choice in this manner, the Nebraska legislature imposed an undue burden on women's constitutional rights. For this reason alone, even independent of the Statute's unconstitutional effect, the Nebraska Statute is invalid under the fundamental principles articulated in *Casey*.

For the reasons set forth above, *amici* respectfully urge the Court to uphold the decision below.

Respectfully submitted,

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March 29, 2000

APPENDIX

DESCRIPTIONS OF THE *AMICI*

The Feminist Majority Foundation ("Foundation") is a non-profit organization with offices in Arlington, Virginia and Los Angeles, California. The Foundation is dedicated to eliminating sex discrimination and to the promotion of equality, women's rights and safe access to abortion and birth control. The Foundation actively pursues legal protection for reproductive health services, and provided legal counsel for Respondents in *Madsen v. Women's Health Center, Inc.*, 512 U.S. 753 (1994), which upheld the use of clinic safety buffer zones.

The National Women's Law Center is a nonprofit legal advocacy organization that has been working since 1972 to advance and protect women's legal rights. The Center's primary goal is to ensure that public and private sector practices and policies better reflect the needs and rights of women. The fundamental right to abortion recognized in *Roe v. Wade* is of profound importance to the lives, health, and safety of women throughout the country. Because of the tremendous significance to women of the freedom to choose whether to bear children, the National Women's Law Center seeks to preserve women's right to abortion.

The National Partnership for Women & Families, founded as the Women's Legal Defense Fund in 1971, is a non-partisan, non-profit advocacy group that uses public education and advocacy to promote fairness in the workplace, quality health care, and policies that help women and men meet the dual demands of work and family. The National Partnership firmly believes that quality health care must include access to the full range of women's reproductive health services. As a result, the National Partnership has a long history of promoting and defending a woman's right to choose by filing *amicus curiae* briefs in major reproductive rights and health cases.

The National Abortion and Reproductive Rights Action League Foundation ("The NARAL Foundation") is a national, non-profit organization dedicated to keeping abortion safe, legal, and accessible for all women. The NARAL Foundation's mission is to work for the right of every woman to make personal decisions regarding the full range of reproductive services, including preventing unintended pregnancy, bearing healthy children, and choosing legal abortion.

People For the American Way Foundation ("People For") is a national, non-partisan, education-oriented citizens organization established to promote fundamental constitutional rights and civil liberties. Founded in 1980 by a group of religious, civic and educational leaders devoted to our nation's heritage of tolerance, pluralism and liberty, People For has over 300,000 members across the country. People For has filed *amicus* briefs before the United States Supreme Court in cases raising important questions relating to a woman's constitutional right to privacy and access to reproductive health services, including abortion.

No. 99-830

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IN THE

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

—v.—

LEROY CARHART, M.D.,

Respondent.

ON WRIT OF *CERTIORARI*
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

BRIEF OF THE STATE OF NEW YORK, ET AL., AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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The State of New York, joined by the States of Maine, Oregon and Vermont, respectfully submits this *amici curiae* brief urging affirmance of the decision below.

STATEMENT OF INTEREST OF AMICI CURIAE

As the chief legal officers of their states, *amici* have a direct interest in the continued vitality of the framework created by *Roe v. Wade*, 410 U.S. 113 (1973), and reaffirmed in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), for balancing women's rights and state interests with respect to abortion. *Amici* share an abiding respect for the judiciary's constitutional role in securing that balance and protecting these fundamental rights.

Amici have found that the balance reached in *Roe* and *Casey* accords to states the necessary authority to regulate abortion in the genuine interest of promoting health and preserving potential life while fully respecting the fundamental privacy and liberty rights of women. Allowing abortion regulations that do not serve these weighty state interests would invite endless legislative and judicial battles and would gravely undermine the unique liberty and health interests that are at stake for women.

Amici have a strong interest, as well, in resisting an approach to statutory construction, urged upon this Court by petitioners and other state *amici*, that would permit a federal court to enjoin a state statute's operation without declaring the statute unconstitutional. This novel and untested approach would, if adopted, subject state officers to contempt proceedings for disagreeing with a court's statutory interpretation, permitting unprecedented federal intrusion into state sovereignty in the administration of state laws.

SUMMARY OF ARGUMENT

The Eighth Circuit's rejection of the Nebraska abortion ban was based on sound statutory construction. The evidentiary record demonstrates beyond doubt that the ban encompasses the dilation and evacuation abortion procedure, thereby unduly burdening access to second-trimester abortion. Petitioners' arguments for a different statutory construction are unavailing: an attorney general's statutory interpretation cannot bind a state; the legislative history does not require a different interpretation; and it is beyond a court's power to rewrite a statute to save its constitutionality.

Petitioners' proffered alternative -- the issuance of "precautionary injunctions" as used by the Seventh Circuit to save similar statutes in *Hope Clinic v. Ryan* -- is an utterly untested means of attempting to conform state enactments to constitutional requirements. This mechanism would subject state officials to contempt charges for enforcing statutes that have not been held invalid, if the officials' statutory interpretation differed from that of a federal court. The approach in *Hope Clinic* endorsed by petitioners, while couched as an exercise in judicial restraint, in fact represents a dangerous and unprecedented incursion by federal courts into state lawmaking that this Court should firmly reject.

The Eighth Circuit's invalidation of the Nebraska statute should be affirmed for another reason, as well. Since *Roe v. Wade*, this Court's abortion jurisprudence has rested on twin principles: first, the Constitution protects a woman's right to decide whether to terminate

her pregnancy by abortion; second, states may regulate abortion to serve their weighty interests in protecting women's health or promoting potential life. The Court's 1992 decision in *Planned Parenthood v. Casey* reaffirmed these principles, and held that abortion restrictions that apply before fetal viability must not unduly burden the woman's ability to obtain an abortion. The Nebraska statute that is now before the Court does not serve either of these state interests and therefore should be rejected.

To permit abortion regulations that do not serve these recognized, substantial state interests would be to devalue the status of the women's liberty and health interests that were recognized in *Roe* and *Casey*. What is more, such permission would invite countless legislative enactments, miring state governments in endless battles while promoting increasing uncertainty about the scope of this constitutional right.

ARGUMENT

I. THE EIGHTH CIRCUIT'S CONSTRUCTION OF THE ABORTION BAN IS CONSTITUTIONALLY SOUND, AND SHOULD NOT BE REJECTED IN FAVOR OF THE SEVENTH CIRCUIT'S APPROACH IN *HOPE CLINIC V. RYAN*

The Eighth Circuit struck down a Nebraska statute that creates criminal penalties for what it refers to as "partial-birth abortion." *Carhart v. Stenberg*, 192 F.3d 1142, 1151 (8th Cir. 1999); *see* Neb. Rev. Stat. § 28-328. The statute prohibits abortions within its definition at any stage of pregnancy, both before and after viability. This litigation is solely concerned with its application before viability. *Carhart*, 192 F.3d at 1148 n.10.

The Eighth Circuit held that this statute bans not only the dilation and extraction ("D&X") abortion procedure, but also the dilation and evacuation ("D&E") procedure. *Id.* at 1150. Because D&E is the usual procedure for abortions during the second trimester, the court below concluded that a statute banning that procedure unduly burdens the woman's choice to terminate her pregnancy before viability and is therefore unconstitutional under *Casey*. *Id.* at 1151.

Petitioners do not take issue with the conclusion, reached below, that a ban on D&E abortions would be unconstitutional. Rather, petitioners urge this Court to reject the Eighth Circuit's construction of the Nebraska statute as reaching both D&X and D&E abortions, and instead to adopt the Seventh Circuit's approach which

gave a "saving" construction to the similarly worded Wisconsin and Illinois abortion bans in *Hope Clinic v. Ryan*, 195 F.3d 857 (7th Cir. 1999). (Pet. for *Cert.*, Question 1). *Amici* submit that the Eighth Circuit's approach to statutory construction was sound, and that the Seventh Circuit's approach, endorsed by petitioners, poses a significant risk to states' autonomy and principles of federalism.

A. The Courts Below Followed Established Canons of Statutory Construction

The evidence in this case required the courts below to hold that the Nebraska ban reaches D&E abortions. Petitioners fault this holding on several grounds, including: first, that the Nebraska Attorney General disavowed any intent to apply the statute to D&E abortions; second, that the language and legislative history of the statute as read by petitioners demonstrate an intent to criminalize only D&X abortions; and third, that the court failed to construe the statute in a manner that would save its constitutionality. (Pet. Br. at 11-12).

Regarding petitioners' first point, this Court has recognized that "as the Attorney General does not bind the state courts or local law enforcement authorities, [this Court is] unable to accept [his] interpretation of the law as authoritative." *Virginia v. American Booksellers Ass'n, Inc.*, 484 U.S. 383, 395 (1988); *cf. Baggitt v. Bullitt*, 377 U.S. 360, 373 (1964) ("[w]ell-intentioned prosecutors and judicial safeguards do not neutralize the vice of a vague

law").[1]

As to the text of the statute, "[c]ourts in applying criminal laws generally must follow the plain and unambiguous meaning of the statutory language. '[O]nly the most extraordinary showing of contrary intentions' in the legislative history will justify a departure from that language." *United States v. Albertini*, 472 U.S. 675, 680 (1985) (citations omitted). Here, the statute bans "partial-birth abortion," defined as "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." Neb. Rev. Stat. § 28-326(9). The court of appeals, citing the extensive evidentiary record before the district court, found that the physician who performs a D&E abortion follows each of these steps, and does so deliberately and intentionally, thereby violating the statute. *Carhart*, 192 F.2d at 1150; *see also Carhart v.*

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[1]This is not to say that the views of a state's attorney general carry no weight. For example, in *Arizonans for Official English v. Arizona*, 520 U.S. 43 (1997), this Court faulted the lower courts' refusal of an attorney general's request to certify to the state courts the question whether a constitutional requirement that the State "shall act in English and in no other language" reached all uses of any other language by an employee while performing official duties. *Id.* at 49, 75-79. Nothing in that case, however, justifies petitioners' reliance on it to establish a rule of federal judicial deference to an attorney general's interpretation of a statute. (Pet. Br. at 8, 12-13, 28). Nor would such a rule be workable, in that it could permit attorneys general to effectively displace legislatures and courts from their respective roles as authors and interpreters of state statutes.

Stenberg, 11 F. Supp. 2d 1099, 1127-31 (D. Neb. 1998). Thus, following the "plain and unambiguous meaning of the statutory language," *Albertini*, 472 U.S. at 680, the courts below concluded that the statute bans the D&E abortion procedure.[2]

Petitioners urge recourse to the legislative history of the statute (Pet. Br. at 22-23), but, as the district court's opinion demonstrates, that history does not provide the "extraordinary showing of contrary intentions" that is required by *Albertini*, 472 U.S. at 680. Rather, the district court found that "a review of the legislative history refutes the assertion that the legislature did not intend to

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[2]As the court below found, the term "partial-birth abortion," "though widely used by lawmakers and in the popular press, has no fixed medical or legal content." *Carhart*, 192 F.3d at 1145. Petitioners assert that the statutory intent is to ban only the D&X abortion procedure (also known as "intact dilation and evacuation") (Pet. Br. at 22-23), in which the body of the fetus is brought into the vagina while the head remains in the uterus, and the head is then reduced in size so it can be brought through the cervix. *Id.* at 1147. The court below held that, contrary to petitioners' assertion, the statute also bans D&E abortions. *Id.* at 1150. In the D&E procedure, the physician dilates the cervix and uses surgical instruments to remove fetal and placental tissue, a process that often involves dismemberment. *Id.* at 1146-47. The D&E procedure falls within the statutory definition of "partial-birth abortion" because "[t]he physician intentionally brings a substantial part of the fetus into the vagina, dismembers the fetus, leading to fetal demise, and completes the delivery." *Id.* at 1150.

ban the D&E." *Carhart*, 11 F. Supp. 2d at 1130.[3]

The Eighth Circuit recognized its "duty to give [the statute] a construction, if reasonably possible, that would avoid constitutional doubts." *Carhart*, 192 F.3d at 1150. Petitioners assert that the court below failed to fulfill this duty (Pet. for *Cert.*, Question 1; Pet. Br. at 24), relying on the discussion of statutory interpretation in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989). This reliance, however, is misplaced. The Justices who joined that discussion in *Webster* (which did not represent the

[3]Both the district court and petitioners quoted remarks by the legislation's sponsor, Senator Maurstad. *See Carhart*, 11 F. Supp. 2d at 1131; Pet. Br. at 22-23. A comparison of the remarks supports the district court's conclusion that legislative intent does not provide a basis for narrowing the reach of the Nebraska statute, as urged by Virginia on behalf of several state *amici*. *See* Virginia Amicus Br. at 10-11. According to the district court:

> One simply cannot ascertain from the legislative history precisely what the legislature wanted to ban. We know the legislators wanted to ban "partial-birth" abortions, but that term is unknown in medical circles and it was poorly understood, if at all, by the legislature.

Carhart, 11 F. Supp. 2d at 1130-31.

Excerpts of the floor debate further support this determination. (*See, e.g.*, Joint Appendix 380-82) (sponsor's statement that substitution of the term "intact dilation and extraction" for the term "partial birth abortion" would change what the bill was designed to do).

view of a majority of the Court[4]) found that the statutory provision at issue, when read in the context of the paragraph where it appeared, made sense only if interpreted in a manner that was consistent with both the Constitution *and* the rest of the paragraph. *Id.* at 513-15. That result has no bearing on the situation here, in which petitioners' proffered construction could be reached only if this Court were to replace the very words of the statute with other words that purportedly more accurately reflect the legislative intent. *Cf. Seminole Tribe v. Florida*, 517 U.S. 44, 76 (1996) ("Nor are we free to rewrite the statutory scheme in order to approximate what we think Congress might have wanted had it known that [a statute] was beyond its authority. If that effort is to be made, it should be made by Congress, and not by the federal courts.").

As this Court wrote in *Albertini*, the requirement that courts follow the plain meaning of the statutory language "is not altered simply because application of a statute is challenged on constitutional grounds. Statutes should be construed to avoid constitutional questions, but this interpretative canon is not a license for the judiciary to rewrite language enacted by the legislature." *Albertini*, 472 U.S. at 680. Indeed, courts "will not rewrite a state

[4]The discussion of statutory interpretation appears in Part II-D of the opinion, *Webster*, 492 U.S. at 513-15. Chief Justice Rehnquist's opinion in Part II-D was joined by Justices White and Kennedy, *id.* at 498, and Justice O'Connor joined its reasoning on the pertinent issue here, *id.* at 527. The fifth vote for the judgment reached in Part II-D was supplied by Justice Scalia, but he "strongly dissent[ed] from the manner in which it [was] reached," *id.* at 537.

law to conform it to constitutional requirements." *American Booksellers*, 484 U.S. at 397. The statute at issue "must be 'readily susceptible' to the limitation." *Id.*; *accord, Reno v. American Civil Liberties Union*, 521 U.S. 844, 884 (1997). This is the canon of statutory construction that the Eighth Circuit applied in stating that it could not "twist the words of the law and give them a meaning they cannot reasonably bear." *Carhart*, 192 F.3d at 1150. Because the terms of the statute banned D&E abortions and thus unconstitutionally burdened the right to choose, the Eighth Circuit correctly struck it down.

B. The Approach to Statutory Construction Urged by Petitioners Is Contrary to State Interests

While *amici*, as states, generally favor methods of statutory construction that uphold state statutes, we cannot endorse the approach, used by the Seventh Circuit in *Hope Clinic*, 195 F.3d at 869, to uphold the Wisconsin and Illinois abortion bans challenged therein, and advocated by petitioners in construing the Nebraska statute.

The Seventh Circuit at the outset acknowledged that the language of the Illinois and Wisconsin abortion bans could be understood by "lay eyes" and by "risk-averse physicians" to bar D&E abortions. *Hope Clinic*, 195 F.3d at 863-64. That court also acknowledged (in *dictum*) that if the statutes did bar the D&E procedure, they would impose an "undue burden" on abortion and

therefore would be unconstitutional. *Id.* at 871. However, the court did not actually hold the statutes unconstitutional. Instead, relying on representations by the Illinois and Wisconsin Attorneys General that their respective legislatures intended the statutes to reach only D&X abortions, the circuit directed the lower courts to enter "precautionary injunctions" against applying the statutes to other than those procedures. *Id.* at 869. The injunctions required by *Hope Clinic* are to apply until the states provide "additional specificity" about the statutes. *Id.*[5]

By this means, the federal court enjoined certain interpretations of state statutes without holding that the statutes violated the Constitution. The Seventh Circuit forthrightly acknowledged this feature of its ruling. *See id.* at 869 ("A skeptic might respond: what's the basis for an injunction without a finding of actual constitutional violation?"). This candor, while admirable, does not excuse the circuit's failure to abide by a basic limitation on federal court power: where "there is no continuing violation of federal law to enjoin . . . an injunction is not available." *Green v. Mansour*, 474 U.S. 64, 71 (1985).

The Seventh Circuit presented its use of the heretofore-unprecedented vehicle of a federal "precautionary injunction" regarding interpretation of

[5]The court implicitly acknowledged that its remedy may not eliminate the statutes' acknowledged vagueness, stating that even with the "precautionary injunctions" in place, there still may be "criminal prosecutions in which the parties disagree about whether the medical procedure properly may be labeled a D&X." *Hope Clinic*, 195 F.3d at 869.

state law as a natural outgrowth of the principle that federal courts owe deference to state court interpretations of state statutes. *See Hope Clinic*, 195 F.3d at 864-69. Specifically, the Seventh Circuit purported to rely on *Bellotti v. Baird*, 428 U.S. 132, 146-47 (1976), for the proposition that "Article III does not limit a federal court's choice to enjoining nothing, or enjoining everything. The path we choose allows the states to interpret their laws and supply more concrete rules." *Hope Clinic*, 195 F.3d at 869-70.

In *Baird*, however, this Court held that abstention with certification to the state court -- not a "precautionary injunction" -- is the appropriate procedure where an unconstrued state statute is susceptible of a construction by the state judiciary that could avoid or alter the constitutional issues. *Baird*, 428 U.S. at 146-47.[6] Thus,

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[6]This, however, does not appear to be an appropriate case for certification to the Nebraska Supreme Court. It is unclear whether petitioners, in the proceedings below, ever sought certification of any question to the state court. Neither opinion below discusses any request for certification, and petitioners' brief refers only to a request for "abstention." (*See* Pet. Br. at 25 n.10). In any event, the standards for certification, as enunciated in *American Booksellers*, 484 U.S. at 395, are not met here. In that case, the Court acknowledged that it "rarely reviews a construction of state law agreed upon by the two lower federal courts." *Id.* (citation omitted). The statute there at issue presented the "rare situation in which [the Court could not] rely on the construction and findings below," because there was "no reliable evidence in the record supporting" the district court's analysis of the reach of the statute. *Id.* Here, by contrast, the district court recited at length the evidentiary support for its holding that the abortion ban

(continued...)

where the Seventh Circuit invoked deference, in fact it engaged in federal judicial activism of the most naked sort.

As states, this approach gives us pause. Most importantly, as the *Hope Clinic* dissenters pointed out, such "precautionary injunctions" "will forbid the enforcement of the statutes outside their core prohibition, thus placing the federal contempt power behind this court's interpretation of state statutes." *Hope Clinic*, 195 F.3d at 876 (Posner, C.J., dissenting). This approach "implies a radical expansion of the power of the federal courts to superintend the enforcement of state statutes. State officials will be subject to federal contempt sanctions for failing to abide by a federal court's interpretation of the statutes that these officials, not federal judges, are charged with administering." *Id.* While in *Hope Clinic* the federal court adopted the statutory interpretation proffered by at least some state officials, nothing in the *Hope Clinic* majority's reasoning confines issuance of "precautionary injunctions" to situations in which relevant state officials agree with the federal court. The future application of this approach is daunting to imagine, as state officials may face contempt charges for enforcing statutes that have not been held invalid.

Nor does the Seventh Circuit's approach serve its stated purpose of allowing states to determine the

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[6](...continued)
reached D&E abortions, and the Eighth Circuit affirmed the district court's analysis in light of the trial evidence. *Carhart*, 11 F. Supp. 2d at 1127-29; *Carhart*, 192 F.3d at 1150.

contours of their laws. The majority styled the "precautionary injunctions" to be issued by the district courts as temporary, stating that the injunctions are "limited to implementing the conclusion of this paragraph that the state laws may not be applied to a normal D&E or induction until after the state has provided additional specificity, by statutory amendment, regulations, or judicial interpretation." *Id.* at 869. However, because they prohibit certain statutory applications, the "precautionary injunctions" may actually prevent cases requiring interpretation of these statutes from ever reaching state courts. *Id.* at 877 (Posner, C.J., dissenting).

This Court, using the language of separation of powers, has cautioned against permitting courts to rewrite federal statutes, because "[a]ny other conclusion, while purporting to be an exercise in judicial restraint, would trench upon the legislative powers vested in Congress." *Albertini*, 472 U.S. at 680. Here, where a federal court is interpreting a state statute, respect for federalism particularly demands rejection of an approach to statutory construction that, "while purporting to be an exercise in judicial restraint," actually would insert federal courts into interpretation of state statutes in new and untested ways.

II. THIS COURT'S PRECEDENTS REQUIRE REJECTION OF AN ABORTION BAN THAT NEITHER PROTECTS WOMEN'S HEALTH NOR PROTECTS POTENTIAL LIFE

A. The Nebraska Ban Must Be Rejected Because It Does Not Serve Either of the State Interests that Justify Abortion Restrictions

Since *Roe v. Wade*, 410 U.S. 113 (1973), the first principle of this Court's abortion decisions has been that the Constitution protects a woman's fundamental right to decide whether to terminate her pregnancy before fetal viability. *Id.* at 153-54. In the years since *Roe*, even as this Court has approved a variety of restrictions on abortion, it has repeatedly reaffirmed this underlying right, most recently stating in unequivocal terms: "The woman's right to terminate her pregnancy before viability is the most central principle of *Roe v. Wade*. It is a rule of law and a component of liberty we cannot renounce." *Planned Parenthood v. Casey*, 505 U.S. 833, 871 (1992).

Also since *Roe*, this Court has recognized that "this right is not unqualified and must be considered against important state interests in regulation." *Roe*, 410 U.S. at 154. In its decisions, the Court consistently has identified two state interests that are weighty enough to justify abortion regulation: "preserving and protecting the health of the pregnant woman" and "protecting the potentiality of human life." *Id.* at 162; *accord City of Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 427-29 (1983),

overruled in part on other grounds, *Casey*, 505 U.S. at 881-84. At the outset of the *Casey* decision, this Court again reiterated that the state interests that are sufficient to justify an abortion regulation are protecting women's health and protecting potential life. *Casey*, 505 U.S. at 846. The decision highlighted the principle that abortion cases involve balancing these two state interests against the woman's constitutional rights: it described the "interest of the State in the protection of potential life" as being on "the other side of the equation" from "[t]he woman's right to terminate her pregnancy before viability." *Id.* at 871. Moreover, abortion regulations must be "tailored to the recognized state interests" that they are intended to serve. *Roe*, 410 U.S. at 165; *Akron*, 462 U.S. at 434 (requiring regulation to be "reasonably designed to further" asserted state interest).[7]

The abortion ban at issue in this case does not serve either of these state interests. Petitioners make no claim that this statute was enacted to protect pregnant women's health. To the contrary, as petitioners acknowledge, the statute does not permit the targeted abortion procedures even if, in the physician's judgment, they are needed to protect a woman's health. (Pet. Br. at

[7]A third state interest described in *Roe*, in "maintaining medical standards," *Roe*, 410 U.S. at 154, is in practical terms essentially the same as the state interest in protecting women's health, *id.* at 149-50. It has not been treated by this Court in subsequent cases as a third or distinct substantial state interest. *See, e.g.*, *Akron*, 462 U.S. at 428-29 (interest in maintaining medical standards is grounded in state's "legitimate concern with the health of women who undergo abortions").

30). Nor does the Nebraska statute promote potential life, because, in petitioners' analysis, it leaves the woman free to terminate her pregnancy by another abortion procedure. (Pet. Br. at 36). Thus, the Nebraska ban does not serve either of the state interests that this Court has recognized as sufficient to justify limitations on abortion.

Implicitly recognizing that its abortion ban does not serve either of these recognized interests, petitioners assert that the ban is nonetheless justified by an interest in "protecting or at least showing concern for a child in an induced birth process," and in "erecting a barrier to infanticide." (Pet. Br. at 49). These asserted interests, however, cannot justify a statute regulating abortion before viability.

Petitioners' reference to "showing concern for a child in an induced birth process" is disingenuous. There is no "induced birth process" at issue here; D&E and D&X are methods of abortion, the indisputable purpose of which is to kill the fetus, not to bring about a live birth. The premise that a fetus that is "more outside the womb than inside [is] . . . . no longer 'unborn,'" and that therefore, a D&X abortion "blurs the distinction between abortion and infanticide" (Pet. Br. at 49) is likewise illogical, because the only reason that the fetus is "outside the womb" is that it is being aborted. The attempt to characterize as "infanticide" an abortion being performed inside a woman's body involving a fetus before viability is flatly incompatible with the right to terminate pregnancy before viability that this Court so recently reaffirmed. *See Casey*, 505 U.S. at 871.

Alternatively, petitioners would expand the state's

recognized interest in potential life to include an "interest in preventing cruelty to partially-born children."[8] (Pet. Br. at 48). Again, in the context of abortion before viability, this attempt misconstrues the nature of the recognized interest in potential life: as detailed in the *Casey* decision, states legitimately may undertake efforts to "persuade [the woman] to choose childbirth over abortion," so long as those efforts do not unduly burden the right to choose abortion. *Casey*, 505 U.S. at 878. However, once the woman has chosen an abortion -- and is in the process of having the abortion -- neither *Casey* nor any other decision permits a state to attempt to prevent "cruelty" to the fetus.

B. As the Nebraska Ban Demonstrates, Permitting Abortion Restrictions that Do Not Serve these Recognized State Interests Would Risk Women's Liberty and Health

A decision by this Court that would exempt legislatures from the requirement that they tailor abortion regulations to the recognized state interests in protecting women's health or promoting potential life would seriously endanger the liberty and health interests that are at the core of the decisions in *Roe* and *Casey*.

First, such a decision would devalue the liberty interest that, as this Court so forthrightly recognized in

[8]Petitioners erroneously use the phrase "partially-born child" to refer to a fetus that is wholly inside the woman's body and is in the process of being aborted.

Casey, is central to women's lives. The *Casey* Court reinforced the "urgent claims of the woman to retain the ultimate control over her destiny and her body [as] implicit in the meaning of liberty," 505 U.S. at 869, and further acknowledged that "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives," *id.* at 856. The Court rejected, *id.* at 845, the dissenters' view that a rational relationship to any "legitimate state interest," *id.* at 966, could support abortion regulation. Instead, it is the state's "*substantial interest in potential life* [that] leads to the conclusion that not all regulations [of abortion] must be deemed unwarranted." *Id.* at 876 (emphasis added). To hold now that *any* asserted state interest may be a sufficient basis for restricting previability abortion would necessarily reduce the weight accorded to the woman's liberty interest, a result that cannot be reconciled with either *Casey* or *Roe*.

Second, such a decision would invite enactment of all manner of abortion restrictions. Even though the legality of such restrictions could be tested against *Casey*'s "undue burden" standard, they could otherwise serve any state interest, or even no state interest. Legislative ingenuity would be their only practical limitation, and the predictable result would be to mire legislatures and the courts in endless battles over abortion regulations while adding to rather than reducing uncertainty over this core constitutional right and the safety of women seeking to exercise it.

The statute at issue demonstrates the dangers of

this course: in an effort to serve other goals, the State of Nebraska has lost sight of its obligation to create an exception for circumstances when a prohibited procedure is needed to protect the pregnant woman's health. Rather, the only exception to the Nebraska ban is when the "partial-birth abortion . . . is necessary to save" the woman's life. Neb. Rev. Stat. § 28-328(1).

This failure to create a health exception to the "partial-birth abortion" ban severely undermines its constitutionality. Petitioners justify this failure on the ground that the D&X abortion procedure is "not medically *necessary*, and safe alternative methods of abortion are available." (Pet. Br. at 30) (emphasis added). Petitioners cite the Seventh Circuit's decision, upholding similar statutes, which relied on a district court's conclusion that the D&X procedure is "never medically *necessary* to save the life or preserve the health of a woman." (Pet. Br. at 30) (citing *Hope Clinic*, 195 F.3d at 872) (emphasis added).

This Court has already held, however, that when a state wishes to ban an abortion procedure, it cannot use medical *necessity* as the only exemption from the ban, because the standard of necessity does not permit "all factors relevant to the welfare of the woman [to] be taken into account by the physician in making his decision." *Colautti v. Franklin*, 439 U.S. 379, 400 (1979).[9] Rather, a

[9]Under the Pennsylvania statutory provision struck down in *Colautti*, when a doctor performing an abortion believed that the fetus was or might be viable, the doctor was required to use the abortion method most likely to result in a live birth "so long as a different technique would not be necessary in order to preserve the life or (continued...)

statute is unconstitutional if it "require[s] a 'trade-off' between the woman's health and fetal survival, and fail[s] to require that maternal health be the physician's paramount consideration." *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768-69 (1986), *overruled in part on other grounds, Casey*, 505 U.S. at 881-84. According to this Court, a state may not require women to submit to abortion procedures that bear *any* increased medical risk over available alternatives, even when the requirement's purpose is to promote the survival of a *viable* fetus. *Thornburgh*, 476 U.S. at 769. If states cannot mandate abortion procedures that may be detrimental to women's health even to promote the state's interest in the life of a viable fetus, they surely cannot ban an abortion procedure that in particular medical circumstances may best preserve a woman's health -- even if the procedure is not absolutely "necessary" -- when the ban promotes *no* state interest.[10] A contrary determination would sacrifice improvements in the safety of abortion to any state interest that might be asserted.

The *Casey* decision strove in part to reestablish the fundamental principles of *Roe v. Wade*, recognizing the

[9](...continued)
health of the mother." *Colautti*, 439 U.S. at 380, n.1.

[10]The district court credited medical testimony that in some circumstances the D&X procedure is safer than other abortion methods. *Carhart*, 11 F. Supp. 2d at 1107-08, 1124-27; *see also Hope Clinic*, 195 F.3d at 883-84 (Posner, C.J., dissenting) (quoting statement of American College of Obstetricians and Gynecologists).

"central right" of the woman to "mak[e] the ultimate decision to terminate her pregnancy before viability," while "accommodating the State's profound interest in potential life" and its ability to "enact regulations to further the health or safety of a woman seeking an abortion." *Casey*, 505 U.S. at 878-89. "State and federal courts as well as legislatures throughout the Union must have guidance as they seek to address this subject in conformance with the Constitution." *Id.* at 845. By applying these principles to invalidate the Nebraska statute -- and particularly, by reiterating that the woman's profound liberty interest in the abortion decision may be balanced only by equally profound state interests -- this Court will provide the necessary guidance to states while safeguarding the liberty and health of women.

CONCLUSION

For the reasons set forth above, this Court should affirm the judgment of the Eighth Circuit Court of Appeals.

Respectfully submitted,

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